THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

DECEMBER, 1945

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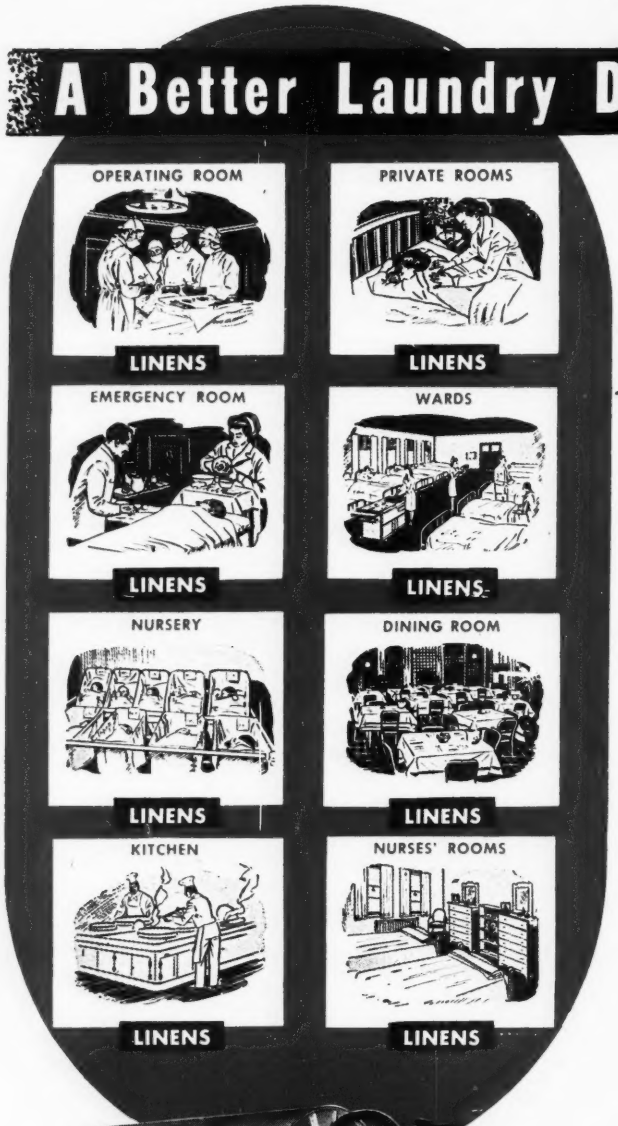

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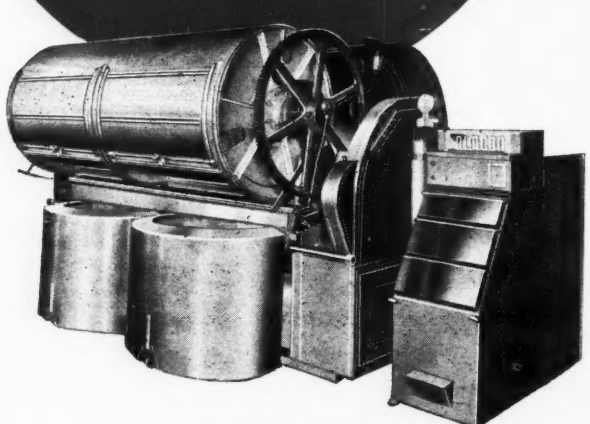

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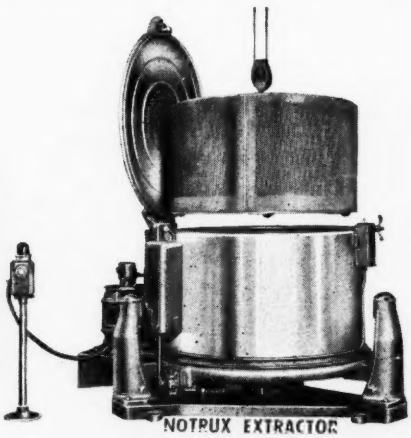

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Vol. 22 **DECEMBER, 1945** No. 12

The Canadian Hospital is the Official Journal of The Canadian Hospital Council

CCAB

Subscription Price in Canada, United States, Great Britain and Foreign, $2.00 per year. Additional subscriptions to same hospital, each $1.00.

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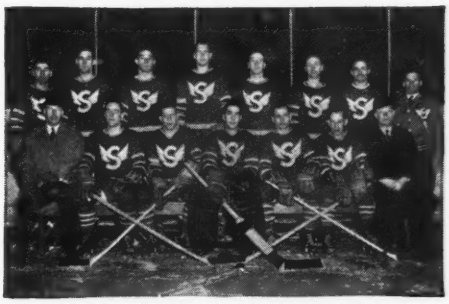

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Across the Desk

By C. A. E.

Production of Menthol

BEFORE the war the United States and Canada obtained practically all their menthol requirements from the Far East, annual consumption fluctuating normally between 400,000 and 600,000 lbs. This was used mainly by the pharmaceutical and food industries. The stoppage of shipments from that part of the world was quite a blow for these manufacturing industries.

American manufacturers sought to promote the production of peppermint but the measures taken did not produce immediate results. It was found, moreover, that the cultivation of peppermint in the United States for the manufacture of menthol was uneconomic. The peppermint plant having a richer aroma and yielding a higher percentage of methol was used for the preparation of extracts rather than for the production of menthol. The yield was equivalent to 55 p.c. as against 85 p.c. for the Japanese product. In addition, the cultivation of the peppermint plant in the United States was adversely affected by the labour shortage.

As a result, Brazil became in short order the almost exclusive supplier of the U.S.A. market, production in other countries of this hemisphere as for instance Paraguay, Nicaragua, Honduras and Mexico being on a comparatively small scale. The cultivation of peppermint in the State of Sao Paulo received a healthy stimulus, with the result that approximately sixty mint distilleries are now operating in that State. The peppermint grown in that State yields between 75 and 80 p.c. of menthol.

* * *

New Polio Centre in New York

New York City's first medical centre for the specialized training of doctors, nurses and other professional personnel in the treatment of infantile paralysis has been established at Knickerbocker Hospital, 70 Convent Avenue.

Establishment of the new unit which occupies the entire fifth floor of the hospital will accommodate 35 patients. A budget of $425,000 has been set up by the New York Chapter of the National Foundation for Infantile Paralysis for special equipment and the treatment of patients. An additional $100,000 has been appropriated by the National Foundation for the educational aspects of the work.

* * *

New Aluminum Venetian Blinds

Aluminum has been known for many years to be an excellent insulator. This principle has been applied to the treatment of windows by using venetian blinds with aluminum slats instead of conventional steel or wood. One side of the slat is polished to reflect the heat, and the other side is satin finished to prevent the metal from absorbing same. Laboratory tests, it is said, show a heat reduction of 75%.

The polished side facing out reflects lights to the ceiling area, affording a more even distribution. The satin side on the inside, absorbing the dominant colors in the room, blends beautifully with the main color combination.

(Continued on page 16)

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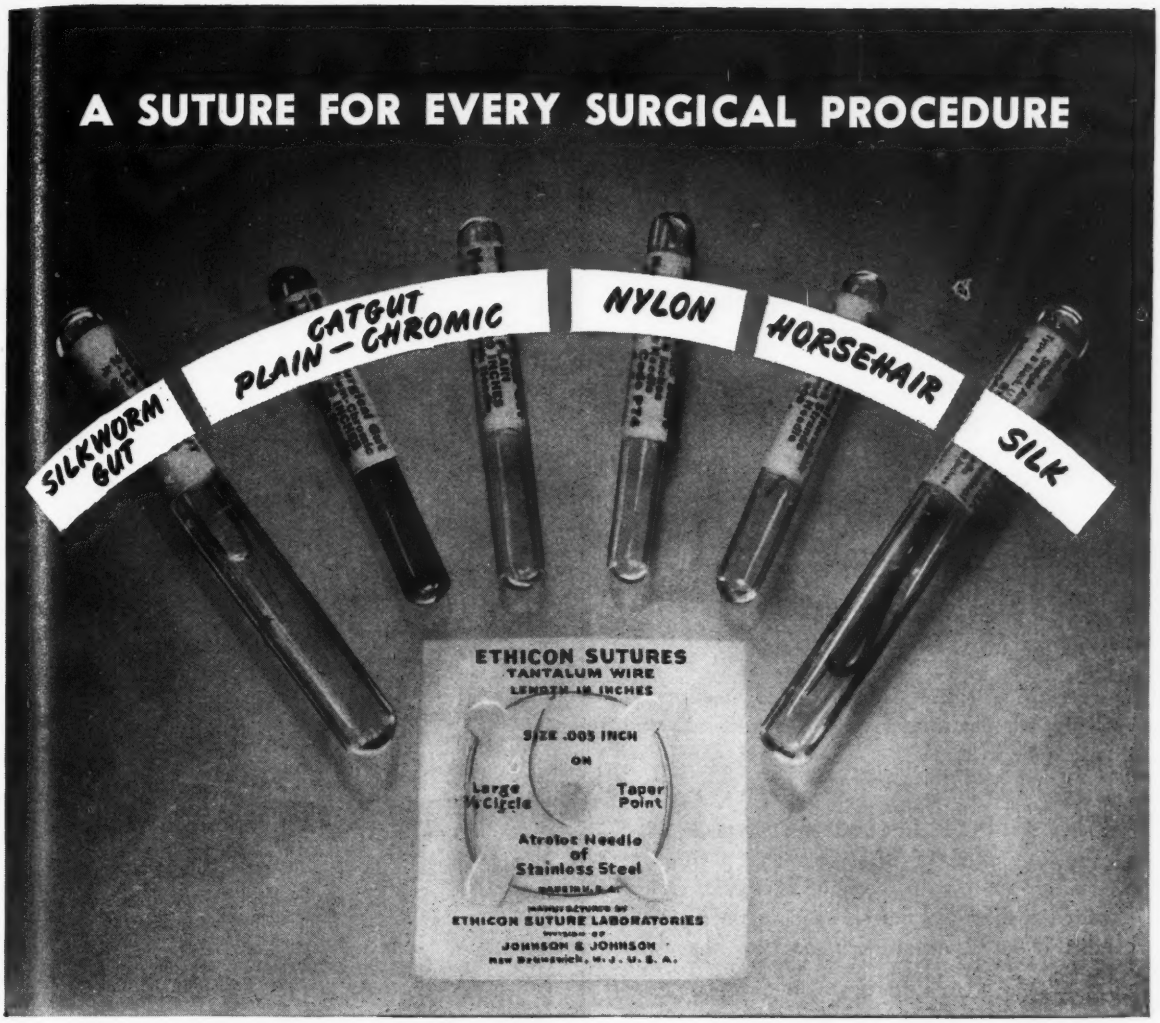

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Across The Desk

"Traffic Master" Gets "Go" Signal

Priority on the "go" signal for the heaviest flow of traffic-pedestrians and vehicles—in any one direction at peak hours is assured by a new device, the "traffic master", announced by Canadian General Electric Co. Limited.

By allowing automatic changes in traffic light systems as often as every 12 minutes during a day under six different programs, the new device will prove a boon to many cities now struggling along with—and swearing at! signal systems which seem to flash more red than green.

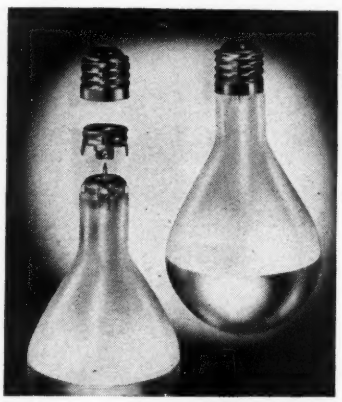
The device can be set weeks in advance to select any one of the six programs for a day's operation. It also takes into account when the busiest intersections need more "go" time, and the side streets require less.

In other words, when the heaviest traffic is flowing toward the factory or the downtown area, the traffic master obliges by telling the system when to rearrange the "go" signals in order to give the rush traffic a non-stop route. Then when there's a reverse in heavy traffic at the end of the working day, the device again tells the system to rearrange the "go" signals for the opposite direction.

* * *

Wabash-Birdseye Lamps Now Permanently Locked

Superlok, a construction that permanently locks bulb to base, and heretofore supplied primarily to the U. S. Government on lamp contract, is now standard on all large Wabash - Birdseye lamps manufactured for civilian use. The new construction eliminates base cementing and neck strapping, and consists of a threaded collar screwed into and notch-locked to the base, with its collar claws gripping the dimpled neck of the glass bulb. The result is a permanent lock that cannot be separated by the weight of the bulb, position of burning, heat or age. All Wabash-Birdseye lamps from 300 watts and upward will be manufactured with this base. Distributed exclusively in Canada by Ideal Electric, Inc., 705 Craig St. West, Montreal, and 21 King St. East, Toronto.



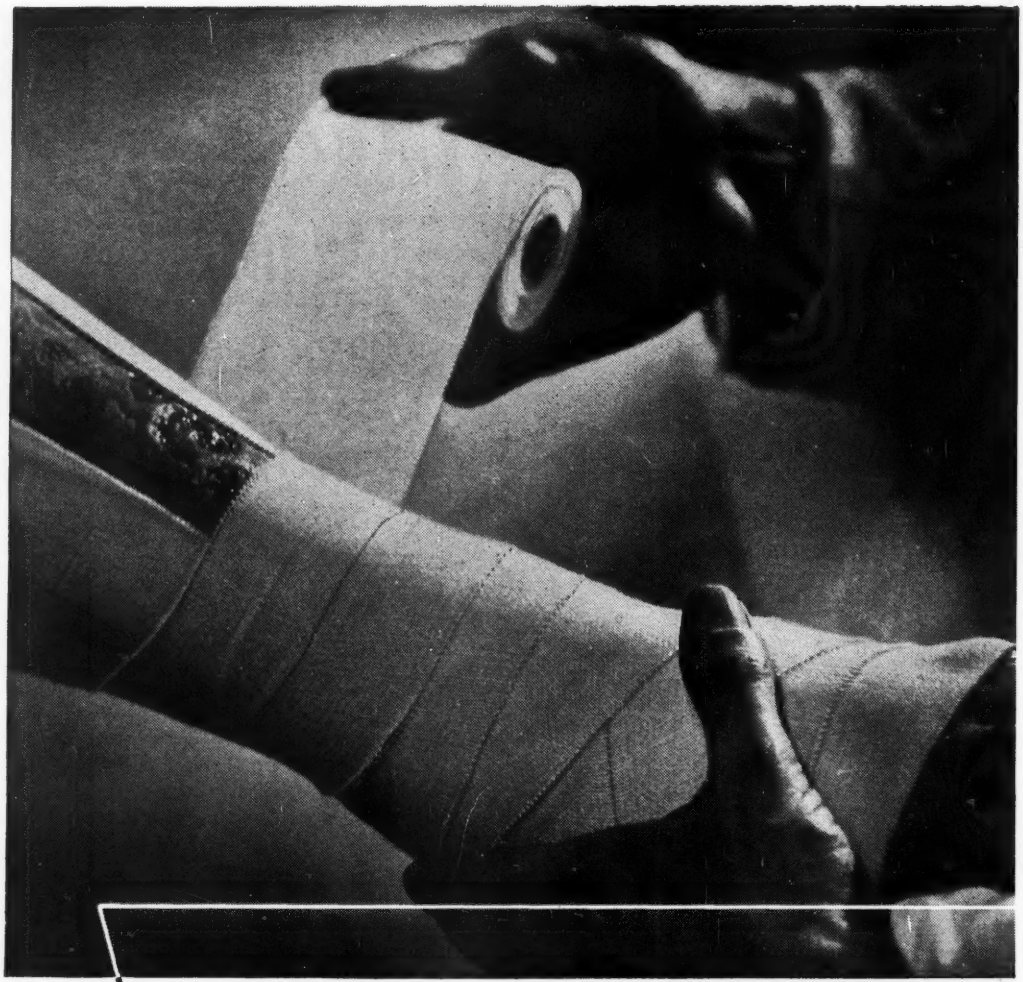
* * *

Baby Pants Production Speeded

A sure sign of reconversion is the announcement by a Quebec manufacturer of the resumed production of rubber baby pants. Long absent from the market, these articles are in great demand by the "younger set". Aluminum forms are used in the manufacturing process and this firm has found that Oakite Compound No. 35, followed by a warm water rinse, does an excellent job of removing talc deposits which accumulate on the forms.

—Oakite News Service.

(Concluded on page 20)



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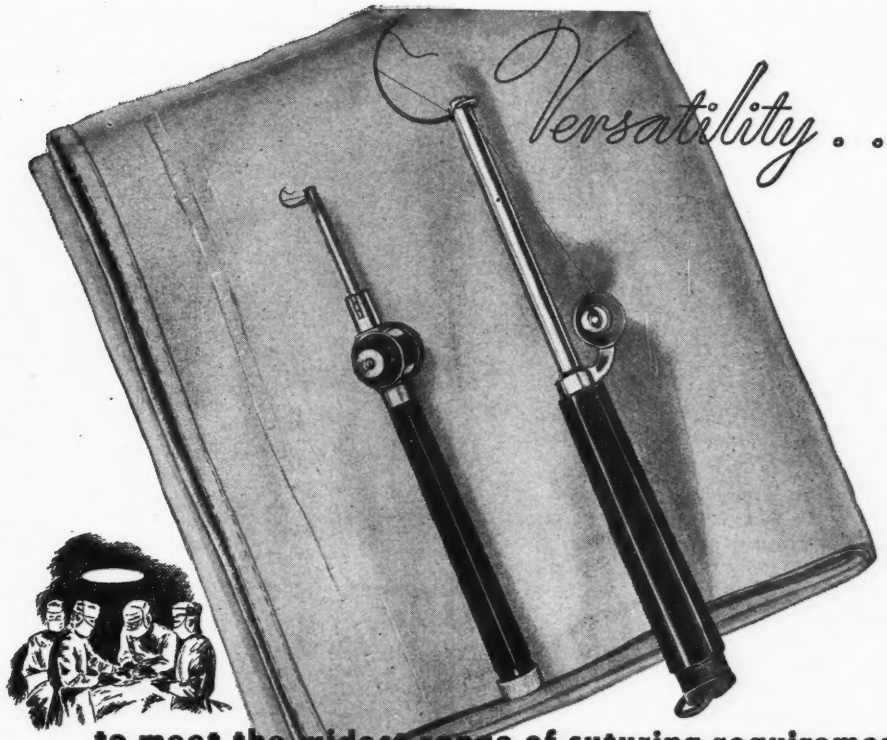

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Across The Desk

Canadian Executive Probes Overseas Markets in Person

T. R. Daykin, President of Hygiene Products Limited, is now in London, England, conferring with Hygiene Products (Great Britain) Ltd., on plans for the expansion of the English company's business. During the past ten years, the Canadian company has built up a large export volume to Great Britain and other countries, of Paper Towels, Drinking Cups, Drinking Straws, Sputum Cups, Toilet Seat Covers and other paper products in which the Canadian company specializes.

T. R. Daykin

While overseas, Mr. Daykin intends to spend some time on the Continent surveying, first hand, the possibilities for increased export of paper specialties manufactured by the Canadian company, to European markets.

* * *

Effective Wetting Agent for Films

A double-purpose wetner has been added to the Supermix line of x-ray film developing materials by General Electric X-Ray Corp., Chicago. One purpose of the solution is to act as a wetting agent for x-ray developer and refresher, the other as an anti-spotting, quick-drying rinse.

As a wetting agent, just 2 cc. of the wetner added to each gallon of developer and refresher produces more even development, less likelihood of streaking, better developer and film contact, less chance for air bell and pinhole formation, elimination of dichroic fog—completely blank spots resulting from adhesion, greater developer clarity, cleaner films and extended developer life.

As a final rinse, 4 cc. of the wetner added to each gallon of ordinary tap water, permits uniform surface water drainage, cuts drying time about 40%, increases dryer capacity, expedites film examination, prevents water-spotted films, and assures greater scratch resistance.

* * *

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The Canadian Speaker Corporation Limited, Montreal, announces a Heatab flame tablet in a much larger size. The new tablet, called the Heatab Jumbo Heatmaker, 1½ inches in diameter and nearly an inch thick, produces safe, intense heat. It starts coal fires or bonfires of damp wood, pre-heats stoves, boils liquids or warms hands in cold weather. Tests prove that a pint of water in a covered utensil boils in four minutes over the flames of the Heatab Heatmaker.

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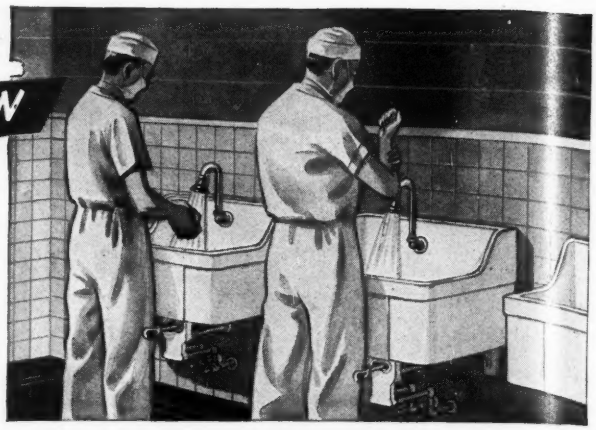

To the surgeon Crane plumbing means, above all else, maximum aseptic safety . . . so essential to modern hospital technique. The surgeon also knows that Crane equipment — designed in co-operation with famous members of his profession—will meet the exacting demands of the many specific hospital services for which it is intended.

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, December, 1945 Vol. 22 No. 12

The Voluntary Hospital in the Future

By OWEN C. TRAINOR, M.D.,
President, Manitoba Hospital Association

THE voluntary hospital as we know it today in this country is the fruition of a long and very honorable tradition. In its earliest beginnings, and for some centuries thereafter, it was a continuance of the work of the good Samaritan, in an expanded and organized form. Succor for the poor and afflicted was provided within its walls without question of a monetary return for the service rendered. Finance was largely a matter of voluntary donation from the wealthy of charitable inclination, while administration and service was provided by members of religious organizations, who devoted their lives to this work, as an integral part of their service to God.

This early voluntary hospital was concerned solely with service to the poor and destitute who were unable to provide for illness out of their own resources; all but the very poor received attention in their own homes.

While this ancient institution is unrecognizable as an exact prototype of the present day modern hospital, all voluntary hospitals partake, in large measure, of this noble heritage of man's humanity to man. The large endowed hospitals of England are still serving, with but a few exceptions, only the poor and destitute, without charge and without assistance from the public treasury. The members of religious sisterhoods still continue their service in the same cause and with the same indifference to personal material award, to the great benefit of suffering humanity.

Evolutionary Changes

Like most other human institutions the voluntary hospital has undergone evolutionary changes. The two most important are the improvement in facilities and equipment for diagnostic and curative medicine and, contemporaneously, the change in economic practice from pure charity to partial payment. The first change took place, *pari-passu*, with the growth and development of medical science, while the second was incidental to a demand from the well-to-do for participation in the manifold advantages in caring for the sick available only in the modern hospital. This participation was accorded on the basis of payment for services rendered, usually on a scale somewhat above actual cost, the surplus accruing being utilized to aid in financing the charitable activities of the institution in the interests of the sick poor. This development proceeded rapidly until, on this continent at least, it is now well nigh universal; practically all hospitals provide three classes of accommodation—private, semi-private and public. The first two are operated at cost, or slightly

Presidential Address, Manitoba Hospital Association convention, Winnipeg, November 5 and 6. Dr. Trainor is medical director and pathologist to the Misericordia Hospital, Winnipeg. He is also a member of the Executive Committee of the Canadian Hospital Council. Like many others in high positions he hails from Prince Edward Island.

above cost, and the last named at a loss. While this system has rendered possible the phenomenal growth in the number and efficiency of the voluntary hospitals during the past half century, it paradoxically enough, contained the germ of "chronic deficit financing" a condition which has plagued these institutions during the past few years.

It was early recognized that profits accruing from pay patients in private and semi-private wards was insufficient to meet the deficit incurred in the operation of the public wards. Appeal to private philanthropy sought, for a time, to bridge the gap between income and expenditure, but it soon became evident that this expedient was a losing battle. The emergence of the hospital into the class of a psuedo-business institution implicit in the practice of charging for services rendered, weakened its appeal to the private philanthropist, and, in many cases, this individual was rapidly becoming a *rara avis*. With the acceleration of income and excess profit taxation, he must presently be considered an extinct species.

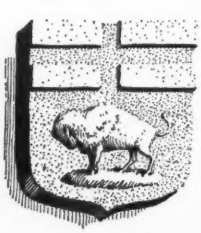
In this financial *impasse* the hospitals turned to governments for assistance, this being solicited on the basis of government responsibility for the indigent citizen. The response of government to this appeal varied markedly as between different jurisdictions, but, on the whole, was widespread. Assistance, in one form or another, was granted to all public hospitals, voluntary or municipal, by governments in all the provinces of Canada. The assistance given to Canadian hospitals has comprised lump sum grants for new construction, government guarantee of hospital bonds, and contributions towards operating costs in the form of annual grants or statutory per diem payments for indigent patients both from governments and municipalities. All these payments were, more or less, in the nature of "hand-outs", intended as partial assistance and, in no sense related to the actual cost of providing service to patients. It should be clearly evident that while all of these measures were of very great assistance to hospitals, they did not solve the age-old problem of the chronic deficit. This failure was inherent in the non-recognition of a commonplace business axiom, that if goods or services are provided at less than cost, a deficit becomes inevitable. There is no escape in the direction of lowered and less costly standards of service. On the contrary, the ever constant advances in medical science and the insistent demand of the people for full participation in all the benefits of such advances, point, unmistakably, to even higher and more costly standards.

In recent times there has been evidence of a change in view - point, in government circles, on this subject. There is a wide-spread disposition to provide a basic hospitalization for all the people on the basis of cost for services rendered. This principle is implicit in federal health insurance proposals and in the various provincial health plans that have already been formulated. Our own Manitoba Health Plan, now on the statute books, may be taken as a prototype of other provincial plans to come. The Saskatchewan plan, as yet in the proposal stage, follows the same general outline.

The foregoing historical background may serve as a useful purpose in directing our attention both to the merits and the deficiencies of voluntary hospitals in the past, and to serve to aid us in a critical evaluation of measures now being brought forward. What should be the criteria of such evaluation? It will be manifest, that the one, all important, consideration should be conservation of all that is meritorious in the existing system coupled with elimination of the defects.

Hospitals and the State

There are those who dispute the right or propriety of government intereference in any form, with the voluntary hospital. Their opposite number would deny the right to existence of the voluntary hospital and would transfer its ownership and operation to the government. We have here, bluntly stated, the *Scylla* and *Charybdis* of the hospital problem and it is altogether probable that the safely navigable channel lies somewhere in between.



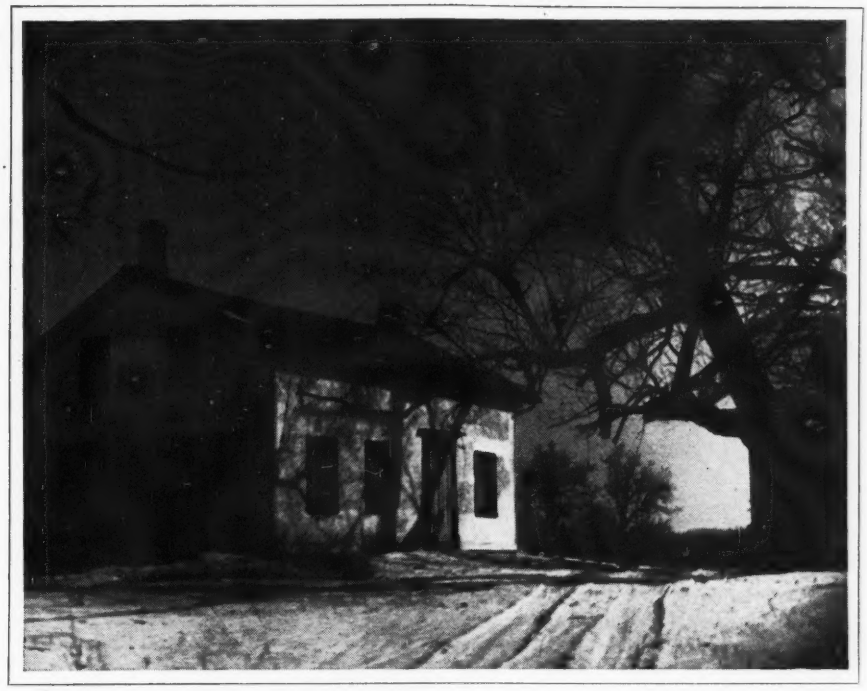
The contention that the state must restrict itself to the maintenance of law and order and to the enactment and maintenance of those laws and institutions designed to ensure the inviolability of unrestricted commerce and private property rights, is a relic of nineteenth century liberalism in an unmitigated and unregenerate form. In its hey-day it laid the foundation of the industrial might of England, but in so doing achieved the economic beggary and social demoralization of whole masses of the English citizenry. The principle of individual freedom is valid only in so far as it does not neglect the common good and entails no injustice to any social class. The modern proponents of this archaic economic creed fail to realize the dynamically progressive character of *true* liberalism. As Hayek says, "Probably nothing has done so much harm to the liberal cause as the wooden insistence of some liberals on certain rough rules of thumb, above all the principle of "laissez faire". The basic and essential principles of liberalism are, in no way, inconsistent with real social justice.

To hold that the state should be restricted in its efforts to achieve social justice is an untenable position. On the contrary it has a moral duty to protect the rights of the economically depressed. The rich can look out for themselves, but the poor, having no resources of their own, must depend on the assistance of the state. This principle enjoys the support of eminent and powerful advocates. Among a host of others may be cited the late President Roosevelt, Ex-Prime Minister Winston Churchill and the two distinguished Popes, Leo XIII and Pius XI. It is important to recognize that these ends can be achieved without sweeping sacrifices of individual liberty.

The foregoing excursion into the realms of political philosophy is by way of background and introduction to an examination of the changing status of the voluntary hospital.

Dawn of a New Era

It is, I am sure, clear to all of you that we, in the hospital field, are facing the dawn of a new era. Gov-



"An Old Ontario House"

Exhibited by Dr. W. K. Blair, Oshawa, in Canadian Physicians' Camera Salon

ernments have declared, clearly and unequivocally, that the health of the citizen is the concern of the nation. That this declaration has the overwhelming, if not the unanimous support of the people, is beyond dispute. The financial implications have been examined, although some would say not adequately and they do not overawe.

When and if the declared intentions of the state are translated into actualities, it is obvious that the major revenues of hospitals will be derived from governments. What does such a situation portend? Does it mean that governments are preparing to pre-empt the hospital field? Does it mean that we are to be confronted with a mammoth bureaucracy of health organized to achieve super-efficiency, under conditions of Hitlerian regimentation of the institution and the individual? Does it sound the death knell of the voluntary hospital? Some there are who would insist that it means all this and more. I, for one, am not prepared to believe that it means anything of the kind. The genius of political liberalism is not dead. The traditions of service of the voluntary hospital and its record of achievement, often under adverse conditions, will not pass into the limbo of forgotten things. Surely our institutions possess the requisite flexibility to allow of their integration into government plans for the common good without sacrifice of essential liberty.

It is true that in all planning on such far reaching and comprehensive lines there exists the threat of regimentation. Bureaucracy, if allowed to obtain a foothold, tends to become insatiable, self-perpetuating and completely subversive of human liberty. The bureaucratic expert is not remarkable for a sense of proportion and is always contemptuous of practical, as opposed to idealogical, considerations. Successful domination by bureaucracy, however, depends on a narcosis of public opinion. The virus fails to make headway against an awakened and enlightened body politic. Eternal vigilance is the price of freedom.

No one should imagine that the changes now imminent, in the hospital field, will be unaccompanied by government regulation. On the contary, regulation is both inevitable and desirable. It is imperative, however, that such regulation be of a character that will not strangle initiative; that it be of a nature that will ensure the greatest possible measure of freedom to the individual institution. It should be concerned primarily with the definition of *standards* and not with methods. It will rightly concern itself with the elimination of waste and the unnecessary duplication of facilities, and here it must exercise a scrupulous fairness towards vested interests and beware of arbitrary decisions, ill-founded in justice.

Rights of Voluntary Hospitals

The voluntary hospital is the legatee of sundry rights and prerogatives, firmly rooted in tradition and based on public service. These rights have been won by our predecessors as a recognition of years of disinterested service in the cause of the public welfare. We are the custodians of this heritage. It is a proud trust. Let us guard it well against any threat of alienation. To do so, we must be forward looking and, at all times, be ready to co-operate in plans wisely designed in the public interest. While reserving the right of intelligent and constructive criticism, we must shun intransigence lest we be cast in the

(Concluded on page 54)

After Six Christmases of War!

BY CHRISTMAS 1939 the first of the Canadian troops had just arrived in England, and we realized as newer before that Christmas is a time of family gatherings—and we felt very lonely in the worst winter England had experienced for three quarters of a century.

Christmas 1940 found the Canadians in the south of England. History was made that Christmas morning in one beautiful old English village church where the Rector and I (a United Churchman) conducted a combined Communion Service for the villagers and the troops. We had a full church in which the real spirit of the Christmas-tide held sway.

Christmas 1941 I was at Canadian Military Headquarters. I shall always remember walking up Fleet Street about dusk to St. Paul's. As I strolled up Ludgate Hill I saw gleaming in the gloaming a huge Christmas tree ablaze with lights on the steps of St. Paul's and lighting up the surrounding destruction. It seemed to be challenging the war-ridden world with its message of Christmas.

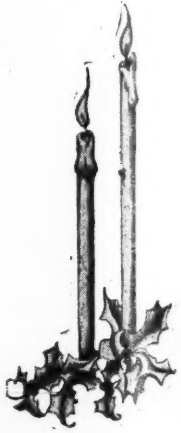
Christmas 1942 I spent with my brother at the Demon Squadron on the East Coast and we sang Christmas carols in a tension that was refused recognition. Three months later he was killed on Coastal Command.

Christmas 1943 I spent with relatives in a Cambridge College where the old chapel and candle light seemed an appropriate setting for carols.

Christmas 1944 I heard those same carols sung in many languages by the Sistine Choir in St. Peters in Rome and watched the Pope as he said Mass at the great altar. Whilst up near Ravenna the Carleton Yorks, the West Nova Scotians, the Royal 22nd, the 48th Highlanders, the Seaforths of Canada and other regiments guarded the line. In the West Nova Scotia were men from British Columbia and in the Seaforths were Maritimers. We Canadians lost in this war a great deal of our sectarianism and our sectionalism—lost it, I hope, forever.

Christmas 1945—and peace again. President Truman has said that the dangerous fighting is over and the dangerous peace has begun. We have defeated a dangerous philosophy with all its regimentation. We now have to put something in its place. The world has once again been bought at a tremendous price. This Christmas-tide we pray with intensity the last prayer William Temple used over the radio:

"O God, make us worthy of Victory".



—Rev. W. T. R. Flemington,
President, Mount Allison University.

St. Mary's of London

By COLONEL W. PARKES, D.S.O., M.C.,
B. Com., House Governor at St. Mary's Hospital, London

A CENTURY ago on the 28th of June, 1845, His Royal Highness, Prince Albert Consort of Queen Victoria of England, laid the foundation stone of St. Mary's Hospital in the Paddington district of London. This action heralded the advent into the world of the youngest member of the family of great Metropolitan Teaching Hospitals. The Centenary of its foundation was celebrated on Thursday, 28th of June, 1945, in the presence of Her Majesty Queen Elizabeth, who has taken a deep personal interest in the welfare of St. Mary's and who has been president of the hospital since 1930.

It may be of interest to review the circumstances which prompted the establishment of what was to become, in the first instance, the main charitable institution for the sick poor of the north-western quarter of London. In order to appreciate the conditions in and around Paddington a hundred years ago, it is necessary to follow the changes from the beginning of the 18th century when, in addition to the beautiful fields and quiet village, the gallows and the gibbet were the principal attractions in the district. By 1821 the population had substantially increased. This increase was an indication of what was taking place in London during the period following the Napoleonic Wars, when, as a result of the Industrial Revolution, London became the great trading centre of the world. In 1837 the Great Western Railway was constructed, and the terminus opened at Paddington a year later, vastly increased the industrial importance of the district, while the rural scene was lost for ever.

The need for a great hospital to minister to the inhabitants of this area became increasingly obvious, and was energetically pressed by Mr. Samuel Armstrong Lane, who carried on a School of Anatomy adjacent to St. George's Hospital on the southern side of Hyde Park. For some years Lane had hoped to be appointed to the surgical staff of St. George's Hospital, but owing to personal differences among its members he never succeeded. St. Mary's was fortunate in having so distinguished a teacher and surgeon to press the claims and need for its foundation. The final result was that St. Mary's Hospital was planned not only as an institution for the treatment of the sick, but also to meet the needs of medical education, and thus had the honour of being the first great teaching hospital in the world to be planned and built as such. After many difficulties the hospital was opened for the reception of patients in 1852.

The hospital began with a very distinguished staff, including four Fellows of the Royal Society, and steadily grew. It attracted some of the greatest figures in medicine, and

Above — Professor Sir Alexander Fleming at work in his laboratory at St. Mary's Hospital.

Among famous London hospitals, St. Mary's, which has recently celebrated its centenary, stands out, not only as the first great teaching hospital in the world to be planned and built as such, but as the hospital in whose laboratory Professor Sir Alexander Fleming was working when he made the discovery that has already proved of such inestimable benefit to mankind—penicillin.

Sir Alexander Fleming has been awarded the 1945 Nobel Prize for physiology and medicine, jointly with Dr. Boris Chain and Dr. Howard Walter Florey, both of Oxford. The award was for the discovery of penicillin.

its school was quickly established as a progressive centre of medical education. At the beginning of the present century, St. Mary's had perhaps the strongest medical staff of any hospital in Britain. Sir William Broadbent, Physician to Queen Victoria, was a great name in his day. Dr. Cheadle discovered the true action of infantile scurvy. Mr. Edward Owen was an outstanding surgeon. Sir Anderson Critchett, Sir Malcolm Morris, Dr. Handfield-Jones and others made up a remarkable team.

Toynbee, a pioneer in aural surgery, founded the first specialized department for diseases of the ear at St. Mary's. Although Toynbee received no court appointment, he treated Queen Victoria for deafness and head noises in 1864. In 1866 he died tragically as the result of an experiment upon himself designed to relieve head noises. He was found dead in his consulting room, having tried to inflate the vapours of chloroform and prussic acid into his middle ear. It is thought that he must have been so deeply absorbed in the effects of the vapours on the ear that he forgot their action on the heart and lungs. It was Toynbee's son who devoted his brief life to social works, and after whom the settlement in the district of Whitechapel in London was named Toynbee Hall.

Among the greatest of St. Mary's men was Dr. Walter, who was Professor of Physiology in the Medical School from 1884-1903, and whose researches into the electrical currents associated with the body established the principles which led to the modern development of the electrocardiograph. This apparatus is one of the most valuable aids in the diagnosis of heart disease, and has led to that most modern and most remarkable of all recording machines, the electro-encephalograph. This instrument, by measuring the variations of the electrical currents in the brain, enables not only the presence of tumours and growths to be detected, but also their actual position. The machine will also detect the presence of epilepsy before the more obvious signs and symptoms appear.

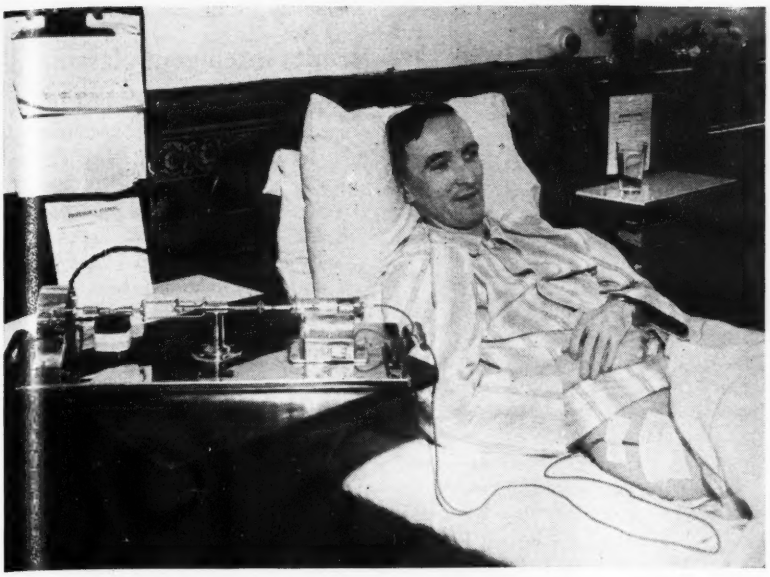
Her Majesty the Queen, President of the Board

In 1908, Sir Almroth Wright started what is now known as the Inoculation Department of St. Mary's, and 25 years ago Lord Moran, Mr. Churchill's personal physician, became Dean of its Medical School. These two events are of the greatest importance to the hospital's present era of success, now crowned by Professor Sir Alexander Fleming's discovery of penicillin, which represents one of the greatest advances in medical history.

Meanwhile, a rapid survey of the more recent advances in medical research carried out at the hospital may be of some interest. Sir Almroth Wright has made history with anti-typhoid vaccine and vaccine-therapy. Just as penicillin in the 1939-1945 war revolutionized the treatment of the wounded and sick to save countless lives, so did anti-typhoid vaccine help the forces of the 1914-1918 war, in quite as spectacular a manner. In the Boer War (1899-1902) typhoid was more dangerous than the enemy's shells and bullets, but in the recent war and that of 1914 - 1918 anti-typhoid inoculation kept the armies free from any serious epidemic.

Research has been developed at St. Mary's principally under the guidance of Sir Almroth Wright, who, with a brilliant team, has been studying the many problems of bacteriology, immunology and chemotherapy. St. Mary's supplies vaccines to doctors all over the world, both for prevention, as in the case of typhoid, cholera and plague, and for the treatment of actual disease as in the

Interior view of a penicillin coach, part of the exhibition train organized by St. Mary's Hospital. The exhibition shows various aspects of modern medicine, and includes a demonstration of how penicillin is produced.



This picture shows the electric or clock drip penicillin administering apparatus in use at St. Mary's Hospital, where it was evolved. A clock, driven electrically, automatically discharges a 20 c.c. hypodermic syringe, and 14¼ c.c.—equal to 200,000 Oxford units of penicillin—is injected intramuscularly in 24 hours.

case of whooping cough, boils, and other septic infections. Success is being achieved in disensitising patients suffering from hay fever, asthma and eczema by inoculation with the pollen or other substances which may have given rise to the particular disease. Work is also proceeding with measures to combat epidemic influenza — the scourge which after the 1914-1918 war killed 21,000,000 people. In the small epidemics recently experienced in this disease, three out of every four treatments have been successful—and so the work of medical research goes on.

Dramatic Success of Penicillin

But it is penicillin which must rank as the greatest of all the discoveries at St. Mary's Hospital. Here is a specific for not one ailment but many. True it is not a "cure-all", but its effect has been dramatically successful upon pneumocci, meningococci, staphylococci, streptococci and upon gonococci. In the treatment of wounds in the recent war penicillin has astonished the world. From the landing in Normandy to Germany's surrender 50,000 of the most severely wounded men were treated with penicillin and 95 out of every hundred recovered; this represents a halving of the death rate which existed in the 1914-1918 war among the seriously wounded.

The discovery of penicillin makes a story which will become a legend. In 1928 Professor Sir Alexander Fleming, who had spent most of his working life in the inoculation department of St. Mary's hospital, was examining some culture plates used for experimental purposes, for the growth of germs. He must have examined thousands of such plates in his life time but his eyes and his brain were trained to note the slightest variation in either the growth or the habits of these germs. On this particular day he saw something which, if it were true, could only mean a revolution in medical practice. A culture plate in which were growing the bacteria called staphylococci had gone mouldy in one spot. For the purpose of this particular experiment the contents of the plate were ruined but they received the same patient and careful examination as every other plate had received over a number of years. Fleming saw that the germs close to the mould were inhibited, whilst those upon the non-mouldy part of the plate were alive and growing. Fired with a new purpose he set about growing more of the mould, which he did by planting the spores or seeds in a fertile medium. He confirmed that this mould, or some derivative, would prevent the growth of staphylococci, streptococci, and other bacteria. Further, he carried out experiments which definitely established the fact that this "germ killer" had qualities which no other known antiseptic possessed. It was the least poisonous to human tissue of any germicide yet discovered. His long and patient researches were at last rewarded by a truly great discovery. Subsequently, Sir Howard Florey and his Oxford team discovered how penicillin could be extracted from the fluid upon which the mould is grown — one of the most difficult problems, which was again solved by long and patient research. Penicillin is indeed a triumph of British science.

In the years between the two Great Wars of 1914-1918 and 1939-1945 remarkable developments took place at St. Mary's. A magnificent medical school was built. The inoculation department was housed in a modern building as a separate and highly efficient unit. A new wing for private patients and a modern nurses' home were also built. No great institution can remain stationary. St. Mary's will undoubtedly play an important part as a 'key' hospital and great teaching centre under any form of national health service which may be inaugurated by the British Government at a later date.

Two sisters listening as Sir Almroth Wright teaches. Now 83 years old, the work of Sir Almroth and his brilliant team of scientists has resulted in St. Mary's supplying the world with vaccines against disease such as typhoid, cholera, plague and recently epidemic influenza.

A code basis that permits intelligent classification and is simpler than it appears.

The Standard Nomenclature of Disease and Operations

By SISTER M. THEODORE, C.S.J., R.R.L.,
St. Joseph's Hospital, London, Ont.

DESPITE the fact that more numerous and more varied attempts at scientific classification had been made in the last century than ever before, it was not until very recently that a real effort to establish an international classification was undertaken. It was for the purpose of remedying the existing confusion in the realm of medical terminology and of uniting the important National societies representing medicine, surgery and their allied specialties in an effort to develop a truly national nomenclature of disease, that the New York Academy of Medicine called a conference on "Nomenclature of Disease" in March, 1928. Among those attending the conference were representatives of the American College of Surgeons, the American Hospital Association, Governmental health agencies and many others. At this conference an Executive Committee was appointed and entrusted with the responsibility of the necessary study for and the preparation of a basic plan.

Under the able chairmanship of Dr. H. B. Logie, a graduate of one of our Canadian universities, and with the financial support of the Commonwealth Fund, a number of insurance companies, and medical and kindred organizations, a system of classification was drawn up which combined many of the best features of previous systems. In 1932 the preliminary edition was published and widely distributed. Since its introduction in 1932 the nomenclature has been revised several times and is now officially sponsored and published by the American Medical Association. The latest revision, published in 1942, is a combined nomenclature of disease and operations.

Need of a Standard Nomenclature

This brief resume of the history and present status of the Standard Nomenclature of Disease makes it apparent that this work has taken a permanent place in the field of medical terminology and disease classification. Its influence is bound to be felt in all our hospitals.

The statement has been made that "*The Standard Nomenclature* is very difficult to learn." *Standard* is indeed more difficult to learn than any other nomenclature, but it is not hard. It takes more or less study depending on whether or not the record librarian must do the coding of diagnosis herself. No record librarian needs to memorize even one of the codes, though, by continuous use of the Nomenclature, she will find herself doing so. She will be much more intelligent, however, in her use of the book if she studies the basic scheme of classification. This scheme is so very logical that it is not hard to grasp and its very reasonableness and explicitness is a daily joy. Once the record librarian has begun to use *Standard* she will find herself richly rewarded, for whatever initial effort it has cost her.

It may be asked, "Why is there so much emphasis on a common nomenclature"? One of the two main purposes that medical records serve in a hospital is the study of disease, methods of treatment, and the nature and importance of medical problems *presented by the various disease entities.* If this purpose is to be fulfilled effectively, it is evident that a uniformity in nomenclature is essential. If two physicians employ different terms, which may not necessarily be interpreted as the same by those who are responsible for preparing the statistical summaries, then the results must necessarily be incorrect. This is a serious problem and emphasizes the need for the general acceptance by hospitals of a uniform nomenclature according to which diagnosis should be recorded.

The proposal for the adoption of a unified system of nomenclature gives rise to a third comment, "Will the small hospitals be asked to use the same nomenclature as the large hospital"? Why not? Are there not in the small hospitals patients suffering from the same diseases as those in larger hospitals? If this be so, then it becomes apparent that the small hospital needs the full list of diagnosis and, therefore, the need of a modification does not exist. *The Standard Nomenclature* as it stands

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Presented at the Institute for Medical Record Librarians conducted by the Canadian Association of Medical Record Librarians at St. Michael's Hospital, Toronto, in October.

is adaptable for use in the small, the large and the teaching hospital.

The Basic Idea

The dual system provides an orderly arrangement for a disease index which keeps all clinically similar diseases together; the list of diagnosis is complete; the terms employed are specific. Also it provides for the classification of partially diagnosed diseases, and undiagnosed diseases, and for the recording of important symptoms. English terms in good usage are employed wherever possible in preference to Latin or Greek.

The *method of classification* for the nomenclature of disease is based simply on two primary factors:

(a) the portion of the body concerned (topographic) and,

(b) the cause of the disorder (etiologic).

This nomenclature has a numerical system of its own by means of which both the anatomical and the etiological aspect of the disease are represented by a code having at least six digits, three representing the *site*, and placed to the left of the hyphen, and three representing the cause and placed to the right of the hyphen. To illustrate:

The main **topographic divisions** are—

000- Diseases of the body as a whole (including diseases of the psyche and of the body generally).
100- Diseases of the integumentary system.
200- Diseases of the musculoskeletal system.
300- Diseases of the respiratory system.
400- Diseases of the cardiovascular system.
500- Diseases of the hemic and lymphatic systems.
600- Diseases of the digestive system.
700- Diseases of the urogenital system.
800- Diseases of the endocrine system.
900- Diseases of the nervous system.
x00- Diseases of the organs of sense.

These major groups are further sub-divided in order to specify a definite organ or part of an organ. Thus for example, as noted above, the digestive system as a whole is designated by the number 600-; the sixth division in the digestive system being in colon, the digits for the colon would be 660-. The descending colon, according to arrangement, is the fifth structure under the heading of colon and receives the code number 665-. Thus, if a disease involves the whole of the digestive tract it will receive the topographic classification 600-, and if it can be positively identified as involving the descending colon only it receives the number 665-.

A similar system of numbering the **causes of disease** constitutes the second portion of the code. These are to the right of the hypen. Thirteen major categories of etiology are included:

-000 Diseases due to prenatal influence.
-100 Diseases due to lower plant or animal parasites.
-200 Diseases due to higher plant or animal parasites.
-300 Diseases due to intoxication.
-400 Diseases due to trauma or physical agents.
-500 Diseases due to secondary or circulatory disturbances.
-550 Diseases due to disturbance of innervation or of physic control.
-600 Diseases due to or consisting of static mechanical abnormality (obstruction calculus, displacement or gross change in form) due to unknown cause.
-700 Diseases due to disorders of metabolism, growth or nutrition.
-800 New growths.
-900 Diseases due to unknown or uncertain cause with the structural reaction (degenerative, infiltrative, inflammatory) alone manifest.
x00 Diseases due to unknown or uncertain cause with functional reaction manifest.
Y00 Diseases of undetermined cause.

As in the topographic classification, these major groups are further sub-divided to specify particular etiologic agents. For example, -400, as noted above, is the code for trauma or physical agents and, under this category, -416 signifies simple facture. Similarly, a caustive agent identified as poison would receive the number -300. If identified as poisoning by a metal it would receive the number -310, but if the metal could be identified as lead it would receive the number -312.

In certain of the etiologic groups it is necessary to insert a fourth digit to indicate the *functional disturbance* produced by the etiologic agent. If one wishes to indicate that poison has produced degeneration, the code number assigned would be -300.9 the digit following the decimal point indicating the resultant degeneration or ulceration. Similarly, ankylosis of the knee due to infection, would receive the number 248-100.4. The 248- is the topographic number to designate the knee, while -100 indicates infection generally. The ankylosis is expressed by the last digit 4, the decimal point being used to show the distinction between the

disease and its results. More specifically, if the ankylosis was due to tuberculosis, the digits would be 248-123.4.

If information for an accurate diagnosis is insufficient, that fact may be indicated at whatever point in the diagnosis the information is lacking. Thus it is possible to code "undiagnosed neoplasm of stomach". This would receive the topographic designation for stomach generally, 640- and the etiologic diagnosis of -8Y0, signifying neoplasm undiagnosed as given on page 615 in the *Nomenclature*. Similarly, undiagnosed disease of the stomach, would be represented by the code 640-Y00.

The index is designed to help the users of this *Nomenclature* to identify and determine the proper diagnostic title and may not be used as a substitute classification. The arrangement of terms is strictly alphabetical, entries being for the most part anatomical. This means that one looks for the disease under the *anatomical* part affected, as for example, "Colon Volvulus of" rather than "Volvulus of Colon". After each diagnosis is the page reference, and then in brackets the eticlogic category, under which that particular diagnosis will be found. Thus the eye scanning the page, can easily spot the diagnosis.

Nomenclature of Operations

The 1942 edition of *Standard Nomenclature* contains a dual system of indexing operations. The operation is expressed on the basis of the structure or organ operated upon (anatomical site) and the surgical procedure employed. The topographical division of the disease classification has been appropriated for the classification of operations.

The nine major types of operation are:

-0 Incision (otomy).
-1 Excision (ectomy).
-2 Amputation (cutting off extremity).
-3 Introduction (injection, insertion).
-4 Endoscopy (scopy).
-5 Repair (plasty, pexy, desis, ostomy).
-6 Destruction (clasis, tripsy, trity, paxy, lysis).
-7 Suture (orrhaphy).
-8 Manipulation.

(Concluded on page 78)

Clear the Deck!

By GEORGE RUDDICK,
Laundry Superintendent, Vancouver General Hospital

FOR the past year the washfloor of the Vancouver General Hospital laundry has been renamed "the deck", the lunch room is now "the mess", the soiled lined "the dobie", the Superintendent's office "the bridge", and the Superintendent is "the old man". The reason for all these nautical terms is that during 1945 this plant has been the training center for laundry crews for His Majesty's Royal Navy Maintenance Ships. Each crew consists of six ratings.

It has been, and will be until the final crew is trained, a most enjoyable experience and when the last crew leaves our gangplank we will miss greatly the various accents and expressions, friendliness and good fellowship these boys from the old land have brought to this plant and, incidentally, to this city.

The laundry departments of these ships are equipped with one thirty-six inch by fifty-four inch wooden washer; one twenty-six solid curb extractor, one thirty-six inch by thirty inch zoneair tumbler, one fifty-one inch Zarmo press (manually operated), two electric hand irons and a combined marking and checking room. This, in my opinion, is a very complete and compact plant which, with trained personnel, is capable of processing approximately eight hundred pounds of linen per day. The training for these ratings requires two weeks and involves a course of general laundry procedure, complete with lectures on the following items:

1. General washing
2. Pressing, ironing, folding; and care of the press
3. Bleach, its use and place in the laundry
4. Marking, listing and distribution of laundry aboard ship.

Then finally one day's instruction is given aboard their ship, processing their ship's linen.

All crews trained to date have shown a very keen interest in the work. Some even intend to follow the trade in their homeland upon receipt of their discharge and have progressed far beyond our expectations. When one considers that these boys are mostly stokers, A.B.'s and stewards, and trained for such duties, their interest in laundering is even more gratifying.

I believe it is correct to say that the installation of laundry equipment aboard such craft as these in the Royal Navy is somewhat of a new procedure. How well I recall my first experience at instructing the Navy! It happened to be a baby flat-top and at a time when considerable shipping was falling prey to submarines so that the natural reaction of the crew to a pantie-waist laundry being installed aboard was to be expected and their voiced opinion very much to the point—"Why the blankety blank put this 'ere mechanical washer-woman on board when it would do a blankety blank more good to put an extra gun on deck?" However, after receiving from their ship's laundry gleaming white suits, sterile blankets and many other items making for comfort and cleanliness both at sea and on shore leave, they think in different terms of this pantie-waist laundry and would be most reluctant to return to the old traditional dobie bucket and elbow grease.

One question I have put to myself since starting this Navy training program (and I believe it will be of interest to many reading this article) is "Do we go to sufficient length in educating our employees to their various positions in a modern laundry?" Believe me when I say that my embarrassment was complete one day

recently when a sailor, fresh from lecture, came to me and said "Those blokes of yourn out there don't seem to know anything about this 'ere saponification, emulsification and deflocculation stuff do they?" Therefore, I say, in teaching others you teach yourself and in this regard who among us is above a little more education? For my part I am guilty and I believe others with me of being too prone to consider the word "training" as nothing more than saying to a new washman for example, "here, Bill, you start the machine in this manner, then you put into the machine some of this and some of that, you run it so long, now you wash the next load". These sailors have been trained differently. They have been instructed, lectured and in general educated, not only in how you do it but *why* you do it and what takes place in the machine while it is being done. This fact is being recognized by the Royal Navy Staff officers in Vancouver and much credit is due them for their splendid cooperation in this training venture. During the past few months it has been my distinct pleasure to meet and discuss ships' laundry problems in general with high-ranking naval personnel, among whom were two admirals, and from these discussions I believe it is safe to predict that future naval building programs will give considerable prominence to the installation of ship's laundries.

Recently the port of Vancouver received a six-day visit (now known as the "Battle of Vancouver" because of our over-exuberant hospitality) from *H.M.S. Implacable* (aircraft carrier); while here the ship's laundry officer availed himself of the opportunity to have his crew assigned to the Vancouver General Hospital for laundry instruction. These ratings, prior to their present duties in the laundry of the *Implacable*, had had no previous laundry experience or instruction. In spite of this handicap they have been doing very well and I feel confident that, as a result of their Vancouver visit, they will perform their laundry duties more efficiently and with much more interest than before.

At this time I wish to thank the various allied trades who have assisted me so ably in this training by supplying booklets, test kits, etc., for distribution to the trainees. Since I believe it would be unwise to mention these firms by name I will merely remark as the Good Book says, "Cast thy bread upon the water for thou shall find it after many days".

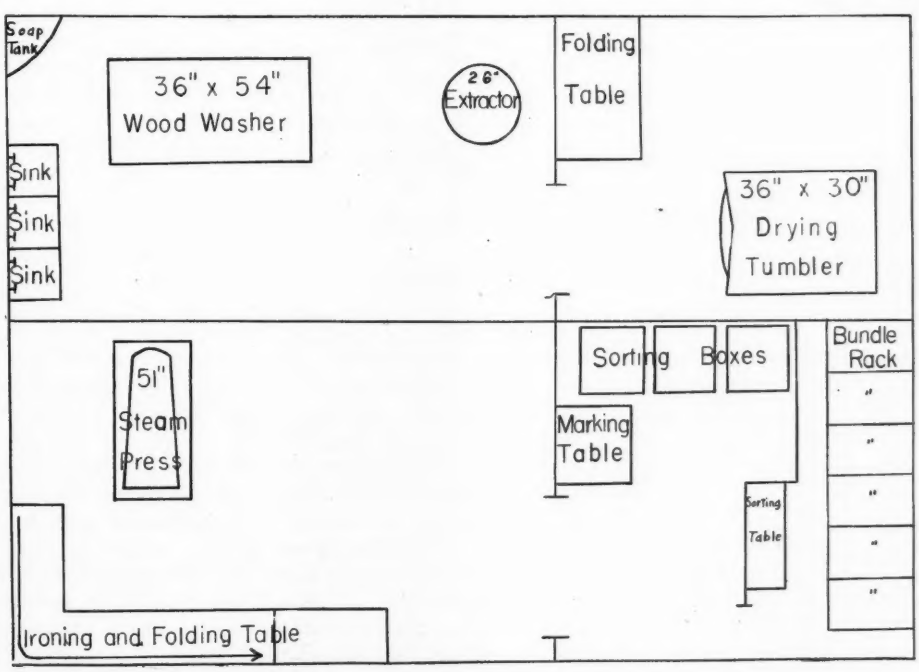
It has been wisely pointed out that a man's age can be measured by the degree of pain he feels as he comes in contact with a new idea.—*The Ambassador.*

$2,000 Contribution to Canadian Hospital Council

To meet the increased demands on the Associated Hospitals of Alberta for its own work and to provide for an increased annual contribution to the Canadian Hospital Council, now to be financed by the hospital associations and conferences themselves, the Alberta body at its annual meeting, agreed by an almost unanimous vote to raise its fees to provide up to $2,000 for the work of the Canadian Hospital Council and approximately $1,500 for its provincial work. This will be achieved by a fee based upon the bed complement which will vary with the requirement from a minimum of 50 cents per bed to a maximum of 70 cents per bed. For all of the mental hospitals there will be a total fee of $500. Each hospital will have two voting delegates for each 100 beds or portion thereof. Maximum voting delegates will be five from the mental hospitals.

Work Started on Alberta Hospital

At an estimated cost of $50,000, work has started on the new Consort Municipal Hospital. The new hospital will be fully modern with accommodation for 20 beds, an x-ray room, case room, operating rooms, isolation ward and nurses' residence.



The Laundry Lay-out.

"The Canadian Hospital" to Offer ANNUAL AWARDS for Best Articles Published

Two Awards—$100 and $50

THE Editorial Board of *The Canadian Hospital* announces that it will make an award of One Hundred Dollars ($100.00) for the best article published in 1946. For the second article selected, there will be an award of Fifty Dollars ($50.00).

These awards will be for the articles which, in the opinion of the judges, best display:

a. Soundness of viewpoint;
b. Originality of thought;
c. Personal research;
d. Good writing;
e. Attractiveness of presentation.

Conditions:

1. Judges will be the members of the Editorial Board of *The Canadian Hospital,* and their decision will be final.

2. Articles submitted must be on some phase of hospital work, or deal with socio-economic movements related to hospital activities, in this country or elsewhere.

3. Articles should be of 1,500 to 3,000 words in length, although these limits are not necessarily obligatory. Articles should be typed, double spaced and on one side of the sheet only.

4. Any article received may be published in *The Canadian Hospital* and the Canadian Hospital Council, through its journal and its bulletins, shall have the sole right of publication.

5. Any person engaged in hospital work, or in a field related to hospital work, and who is not a professional writer, will be eligible for this award, irrespective of the country in which he resides.

6. Articles received but not published in 1945 will be eligible for a 1946 award; articles received in 1946 but not published in 1946 will be eligible for the 1947 award.

Federal Aid Will Hasten Saskatchewan Health Program

Premier Douglas Outlines Objectives

IF the present federal proposals materialize, the eight-year health program of the Saskatchewan government may be capable of completion within four to five years, stated the Hon. T. C. Douglas, Premier and Minister of Health at the annual banquet of the Saskatchewan Hospital Association.

The program in mind would cost about twenty millions of dollars. With 60 per cent contributed by the Federal government, Saskatchewan would need to raise only some eight or nine millions.

The government has had to face three main problems—finance, trained personnel and adequate facilities. The present program of grants and loans will increase hospital facilities from 3,900 to 5,000 beds, an increase of 26 per cent and provide some 5.9 beds per thousand of the population. However, the distribution of beds will still not be entirely satisfactory. At present the government is trying to interest people in setting up health regions. Each would have a health services board and a medical officer with a staff for preventive work. The plan is to decentralize both control and activities. The Provincial government will pay a substantial portion of the curative and diagnostic work.

Objectives By Stages

The aim of governments has been to put all prolonged and, therefore, costly illnesses on the free list. This has included tuberculosis, cancer, mental diseases and venereal disease.

The second objective, already undertaken by this government, has been to put on the free list the medical and surgical care of a large "marginal" group, such as the blind and those receiving old age pensions or mothers' allowances. To these will be added some 8-10,000 who are physically incapacitated, such as paralytics, arthritics and others.

Later general health care will be extended to all of the people.

In the next twelve months the Department hopes to work out a complete hospital scheme for the province. The Association is being asked to name a committee to work with the Government. (This was done the next day. Ed.) *The plan will be on a contributory basis,* the people to be asked to pay so much per head into a common fund to meet the cost of hospitalization.

After hospitalization is provided, it is proposed to add general practitioner service, specialist service, nursing care, diagnostic services, dental care, pharmaceuticals, etc.

The co-operation and goodwill of the hospitals is needed. The Government, said Mr. Douglas, is willing to sit down with the hospitals and work out plans satisfactory both to the hospitals and to the Government. The people who work for our hospitals do so to help suffering humanity. They are as desirous as anyone that the best possible hospital facilities be available for their neighbors. It is important that all of our people have access to the best hospital, medical and surgical services which are available.

Plan Air-Ambulance for Saskatchewan

A Norseman aircraft, to be used for southern area coverages in an air-ambulance service operated by the Saskatchewan government, is being inspected and licensed at Edmonton by the federal Department of Civil Aviation.

The Hospital and the Church

REV. JEFFREY BILLINGSLEY,
Rector, Holy Trinity Church, Chatham, Ontario

IT is only natural that the church should be interested in the hospital in as much as mercy is a Christian virtue and finds its expression in the care of the sick in hospitals. If that were the sole reason for the Church's interest and support, it would be sufficient; but it is more than that.

The Lord Jesus Christ, the Head of the Church, was undoubtedly interested in the physical as well as the spiritual welfare of men and women. We cannot account for His ministry of healing, which was a long fight against all kinds of disease, in any other way. He went about doing all manner of good and healing all manner of sickness. It follows then quite naturally that with such a Head as Christ, Whose works of compassion and mercy are recorded on the pages of history, the Church, imbued with His Spirit, should give birth not only to institutions of culture and learning, of service to the unfortunate and outcast, but also to those which care for suffering humanity, our hospitals. Besides finding their birth within the Church, they were also nurtured by her through their critical infancy. Then as they attained maturity and sufficient strength to exist independently, the church sent forth to continue their development as secular enterprises, sometimes unfortunately, not without the struggle and hard feelings so characteristic of the adolescent's break from home.

In the light of what has just been said, is it any wonder that the Church has a deep and abiding interest in "the hospital", serving men and women through the healing of their bodies, in the spirit and in the name of the Lord Jesus Christ.

The church is further interested because the real spirit that inspires faithful, efficient, and devoted service in those who have anything to do with the ministry of healing, is the Spirit of Christ, the Great Physician. He is behind the service rendered by those fine men, the doctors, whose time and skill are utilized in combating disease, as He also inspires the nurses, whose sympathetic hands move tenderly in the care and comfort of the sick. The keynote of public service, for the prevention of illness, the relief of human suffering, and the restoration of health could only be the result of His Spirit. And if a hospital has a policy of sufficient service to all regardless of race, colour, creed and the ability to pay, you can be sure that Christ is there, as He is present with all the employees of that hospital, who desire more intimate knowledge and understanding of their job, only that they may be more alert to the demands of their task, and may better serve those who suffer. The Church, which embodies the Spirit of the Lord Jesus Christ, is certainly interested in any such institution empowered by that same spirit to serve.

And the Church is interested too, because, in obedience to Christ's command, she actively co-operates with the hospital in bringing spiritual strength and comfort to the suffering in their hour of need, which is a part of the great task of physical healing. The Church brings Christ to the patient.

Let me summarize then: Because the Church is actually the parent of the modern hospital; because the Church is the source of inspiration to those who, connected with the hospital, serve suffering humanity; and because the Church is a co-operator in the ministry of healing, therefore she is naturally interested in the welfare of that institution, which serves the community. To support our hospitals is to follow closely in the footsteps of the Great Healer of men, Jesus Christ, the divine Head of the Church.

New Runnymede Hospital

For the Care of the Chronically Ill

A 130-BED hospital for the accommodation of chronically ill and aged indigent patients was officially opend in Toronto on October 17th. Patients are being moved in and it is hoped that this new institution will alleviate to some extent the overcrowded conditions in the acute general hospitals.

Under the sponsorship of the civic administration, a 16-room school building has been converted into a modern hospital at a cost of $1,500 per bed. There are twenty-five beds reserved for those who wish to pay but the hospital has only one private room. The largest ward has twelve beds, each of which is curtained for privacy. The first floor is for male patients only and the second for females.

Throughout the building every foot of space has been used to the best advantage and the most up-to-date equipment installed. The bedside service cabinet, illustrated, was especially designed for the use of chronic

Above: Living Room.

Left: A two-bed Ward.

patients. It combines the functions of a bedside table and a chest of drawers. Moreover it is fitted with a two-way overbed leaf which can be used for writing, games or as a meal tray. It has also a centre drawer with an adjustable top which may be used as a tray when the patient is in a wheel-chair. Food is carried to the wards in heated conveyors. There are new-style, foolproof call lights. When a patient rings, a light shows over the bed, outside the door, at the nurses' station and in the utility room. At the same time a buzzer works as well.

The decorating was conceived with an eye to the therapeutic value of colour as well as the utmost in attractiveness and durability. All ceilings are painted a soft restful green and the walls are pastel with inlaid borders. No two wards are alike and lighting is indirect. The up-patients' lounge is gay with flowered chintz and comfortable in every detail. Inlaid linoleum in soft tones makes an ideal floor covering and the walls of corridors, service-rooms and bath rooms are done in muroleum. The building is an outstanding example of successful remodelling.

Runnymede Hospital has a staff of 36 graduate and assistant nurses. The Superintendent is Miss Bianca M. Beyer, R.N. and Dr. Charles O. Broad is Chief Attending Physician.

Above: The Lobby.

Left: Superintendent's Dining Room.

Below: A Corner of the Kitchen.

Above photographs courtesy The T. Eaton Co. Ltd. Photograph of kitchen courtesy of Robt. Simpson Co. Ltd.

Obiter Dicta

Manitoba Passes Motorist Legislation

EFFECTIVE December 1st, a timely advance in legislation relating to motor accidents became effective in Manitoba. From now on reckless drivers who are involved in accidents causing damage to property or injury to a person will not only be liable for damages and liable to conviction and penalties under the criminal law, but will also be unable to do any more driving unless they can give proof of financial responsibility. Of still more significance to hospital executives and to the medical profession as well as to the public, is a provision which protects to a considerable degree those who, in the past, have been unable to collect for services rendered or for damages sustained. This is the provision that, after December 1st past, all drivers of motor vehicles must be able to show proof of financial responsibility. This is achieved in a roundabout method but one which should prove quite satisfactory within a short time. It is an offence not to be able to show proof of financial responsibility if a driver is involved in an accident. His driver's permit and the registration licence of his car will be suspended and the driver's permit or licence can only be restored after he has taken out public liability and property damage insurance or has given a bond for the same purpose. An alternative procedure is to deposit with the provincial treasurer money or security for $11,000 for each car. There will be, also, a special fee of $1.00 charged to each motorist to create a special fund to meet those instances in which damages exceeding $100 have been awarded for body injuries and in which the person liable is unable to pay.

This will be welcome news to all who have had to care for those injured by reckless driving or jay walking and who have not been able to collect. The very ones who most need compulsory liability insurance are the very ones who do not carry it. It has been surprising to hospital and medical association representatives to note the opposition to any obligatory type of insurance. Liability insurance company representatives have strenuously opposed the proposals, apparently on the ground that, if everybody were insured, there would be widespread carelessness and indifference to public safety. We have never been able to accept these arguments and have felt that American statistics quoted were entirely misinterpreted. Two of the provinces followed Manitoba's early lead in setting up a "gentlemen's agreement" with respect to notification of the hospital and the doctor when insurance damages were paid, but this did not prove satisfactory. The best arrangement hitherto has been the "Charitable Institutions Injured Persons Costs Privileged Payment Act" passed in Quebec in 1935. This required a hospitalized patient claiming damages to include the account of the hospital and of the physicians in his claim. In any settlement these accounts would be paid directly, thus avoiding the common experience of having awards for medical and hospital damages kept by the claimant or used for other purposes (see Canadian Hospital Council bulletin No. 30, page 78).

Research in Canada

CONSIDERING how limited have been our facilities for research in Canada and what little encouragement we have given to research, it has been remarkable that this country has made so many notable contributions in various fields of science. Perhaps, if we could look at this subject objectively and discount our proximity to Canadian studies and our natural national pride, the achievements, in the light of

what has been done elsewhere, would not total up so impressivly. It is significant when Dr. E. W. R. Steacie, Director of the Division of Chemistry, National Research Council, states as he did recently: "We have been rather a backward country in science and Canada has never been noted for its support of research, especially fundamental research." It was his opinion that Canadian universities are poorly equipped generally for research and little encouragement is given anywhere in the country for the scientist in pursuit of fundamental knowledge. Facilities in many universities are not as good as those in even small industrial plants.

It should be stated that the National Research Council has done magnificent work; many of its wartime achievements are quite unknown to the public. Its budget, however, has never been sufficient for the need, and continually it must decline to undertake work not strictly within the limits of its none-too-broad range of investigation. The Ontario Research Foundation, working with a number of industrial concerns, has made many notable contributions to the development of industrial methods. Although the facilities of some of our universities have been limited, as Dr. Steacie points out, others have been fairly well equipped and, collectively, they have made many contributions to pure science, to medicine, to engineering and to other fields. Our total efforts, however, seem so meagre even allowing for difference in size, when we compare them with what has been done elsewhere, in Germany particularly, but also in Russia, in the United States and in Japan.

This war has focussed attention on the value of scientific research as had never been done before. Canadian scientists shared with those of Great Britain and the United States in making the production of penicillin a commercial feasibility and in working out the large scale processing of blood. Our research men shared also in the even more spectacular achievements of harnessing the atom and developing radar. In the health field the medical profession has urged the federal government to make liberal provision for research in its subsidies towards health insurance, for research in prevention and treatment should be considered an essential part of any national health programme. There is good indication that this will be provided in some degree at least. Obviously a new scientific era is before us and it is hoped that all kinds of scientific research, as approved by screening committees with vision, will be given adequate funds for personnel and facilities by the Dominion, by the provinces and by industry. But we must do more than hope; we must insist.

Visiting Nurse Service

THE proposal of the Federal Government that the "first stage" of its health insurance program to be entered into with the provincial governments should provide for three specific types of health benefit may have undergone some revision at the conference with the provincial premiers at the end of November. Actually, owing to the time factor in getting out a magazine like this one, any changes acceptable to the Federal Government at that meeting may have been announced before the publication of this issue. The "first stage" of the Federal proposal as made last August provide for three benefits—general practitioner service, hospital care and visiting nurse service. Manitoba desires to see "visiting nurse service" replaced by "diagnostic services" and we understand that Saskatchewan strongly supports this view. Diagnostic services have been listed for the "second stage".

There is some logic in this viewpoint. Early and accurate diagnosis is a *sine qua non* in medical care. Delayed or inaccurate diagnoses account for more deaths than the lack of treatment facilities, or the lack of money to pay for treatment. Modern medicine can make early diagnoses not hitherto deemed possible but this often requires highly technical procedures and expert interpretation. In many parts of Canada such specialized assistance is not available and, where it is obtainable, is expensive, time consuming and not well organized. The Committee on Economics of the Canadian Medical Association in June placed this third in its list of the seven "Basic Requirements for the Improvement of Health Services". These were (1) a preventive program, (2) provision for medical and allied services for remote areas, (3) diagnostic services, (4) hospitalization, (5) full coverage for the welfare group, (6) educational program for the public and the professional and (7) improved standards of living. With reference to diagnostic services the Committee stated:

> **"A primary need for the improvement of health services in Canada is the provision of adequate diagnostic facilities throughout the country. No patient should be unable to obtain the benefits of modern highly developed diagnostic procedures because of geographic inaccessibility or lack of financial means . . ."**

It is questionable, too, if it will prove very easy to work out a satisfactory basis for a visiting nurse service. This has been put down at one-tenth of the cost of general practitioner service, or 60c per head per annum. The total Federal contribution towards this visiting nursing service would be $4,136,000. No one knows what will be the public demand for a visiting nurse when her services become available without charge. V. O. N. and other statistics, valuable though they are, can only be applied in part. We do know that a voluntary prepayment nursing service started in Calgary some years ago did not last long because of the unanticipated heavy demands on its services. The extent of the drain upon this particular feature may only be limited by the probability that for some years to come there will not be enough nurses available to meet the demand.

Actually in selecting those three benefits for its first stage the Government showed courage—or sumpin' else. For general practitioner coverage, we have as yet no reliable statistical data applicable to the whole population of an average large area. In administration this benefit will occasion more headaches than any other. Hospital costs will be much easier to define despite a likely 15-20 per cent increase in demand, but hospital benefits cannot be provided in any province unless preceeded by a vast building program. Apparently some steps are being taken in this direction but a lot will need to be done and much money will be required.

Saskatchewan Association Meets at Yorkton

THE 27th annual convention of the Saskatchewan Hospital Association proved to be an excellent one despite the short time available, since the lifting of the ban on conventions, for the preparation of a programme. Drifting snow and zero weather delayed some of the delegates but they got there just the same. President, S. N. Wynn and Secretary, John Smith, both of Yorkton, were in charge of arrangements. In their addresses they revealed an unusually active year with many studies and developments under consideration.

The annual analysis of hospital statistics and progress, a feature of the Saskatchewan meetings, was presented this year by Clarence C. Gibson, Director of Hospital Administration.

Again the unnecessarily high rate paid by hospitals for fire insurance was deplored by Joseph Needham of Meadow Lake, chairman of a committee which had already pointed out the few losses sustained by hospital fires. Dr. C. F. W. Hames, Deputy Minister of Public Health, gave a denial to a press report that the government planned to require all institutions receiving grants to take out government fire insurance. However, if a block of hospitals wished to do so, low cost fire insurance could be provided by the government. On his suggestion the Association agreed to appoint a commitee to meet the government's insurance committee.

Classification of Hospitals

The classification of hospitals to permit a more equitable payment of grants was considered by Dr. Kirk, the assistant deputy minister, and elicited much discussion. A classification on a basis of units of credit for facilities available is favoured, but the Department is moving carefully so as to be fair to all. Some fear was expressed that the small hospital might suffer, but several speakers were of the opinion that the plan should be particularly helpful to the progressive small hospital. While awaiting the completion of a general plan of classification, the Workmen's Compensation Board has agreed to give hospitals with schools for nurses an extra twenty-five cents. Mr. H. Bassett of Prince Albert, favoured a grading of grants as the solution and thought that there might also be direct contributions to small hospitals to permit them to improve their service.

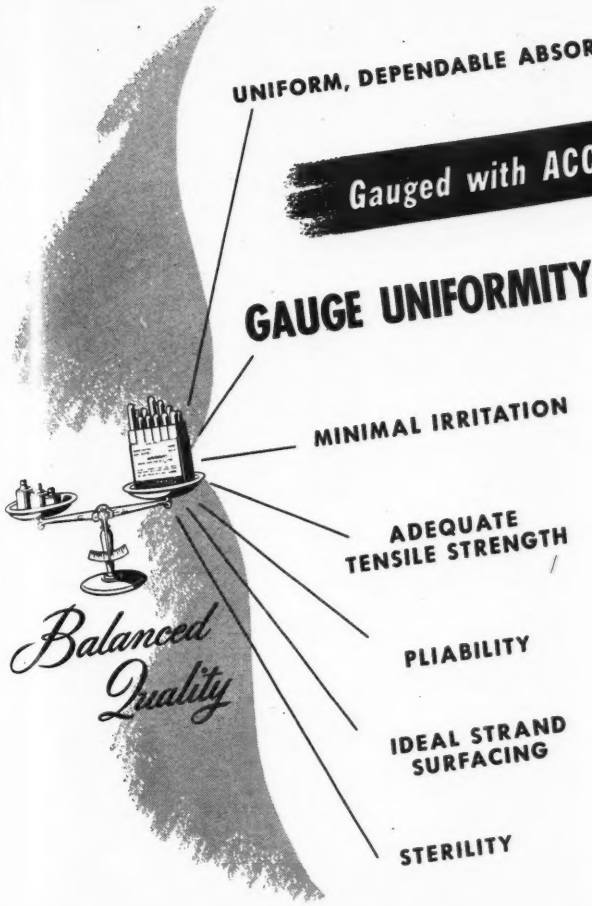
Minimum Wage Act

The present Act was interpreted and many questions asked by Mr. J. H. Williams, the Deputy Minister of Labour. In his opinion the honest employers have nothing to fear from this legislation, as it helps to control unscrupulous employers who would reduce costs by lower wages. The Board has set a living-in allowance of 20 cents a meal and 25 cents for a room and recognizing 26 days a month. This was protested in the discussion, as hospitals could not afford to provide adequate quarters and meals for that amount. Also, the basis should be for 30 days a month.

"Present Day Hospital Problems" were reviewed by Dr. Harvey Agnew. He dealt largely with recent and proposed federal and other legislation. Mrs. Elhatton of Moose Jaw, president of the Women's Hospital Aids Association, spoke of the work of the Aids throughout the province and urged that all hospitals develop active organizations.

Photo courtesy Northern Credits Limited.

Left to right—E. G. King, Lloydminster; J. C. Saunders, Saskatoon; Harvey Agnew, M.D., Toronto; President W. C. Ryan, Regina; Past-president S. N. Wynn, Yorkton; E. H. Rice, Swift Current; John Smith, Yorkton.



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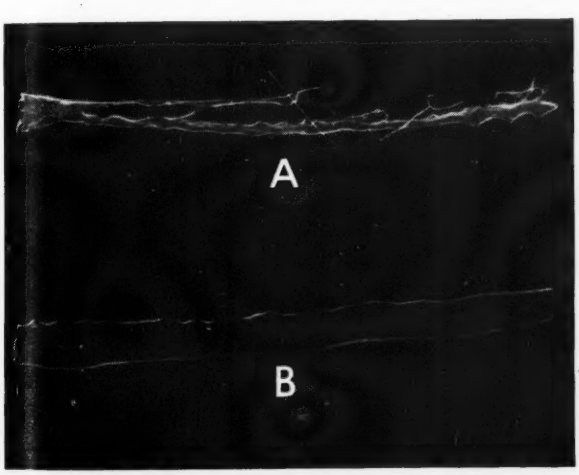
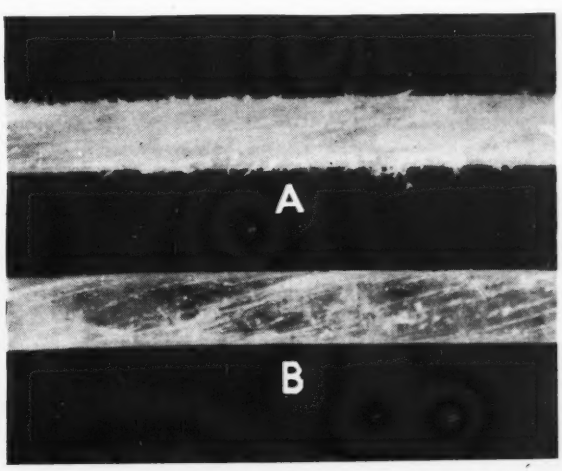


Untwisted plies recovered from two catgut strands polished to different degrees.
A—Ply or ribbon, recovered from an overpolished suture strand.
B—Ply from Curity strand not polished to gauge.



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Above—Miss K. W. Ellis, Saskatoon; Miss Grace Giles, S.R.N.A., Saskatoon; Mrs. Leonard Shaw, Moose Jaw.

Above — Sister Manden, Saskatoon; Sister Peter Marie, Broadview; Sister Seraphina, Humboldt; Sister Mary de Loyola, N. Battleford.

Above—Secretary John Smith, Yorkton; J. O. Dale, Melford; Alex. Esson, Saskatoon.

Above—Rev. J. F. Floyd, Gerald; Rev. J. Burns, Esterhazy.

Above—Dr. Kirk, Dept. of Health; Dr. J. G. K. Lindsay, Reg. C.I S.S.; Joseph Needham, Meadow Lake.

Above — Sr. Frances Therese, Tisdale; Sr. St. Bride, Esterhazy; Sr. Gonzaga, Estevan.

Above—S. N. Wynn, Yorkton; Dr. C. F. W. Hames, Deputy Minister; J. H. Moysey, Eston.

Doctors and Health Insurance

Dr. Lloyd Brown of Regina stated that the medical profession in seeking adequate consideration for its own rights, has asked for equal consideration for the rights of the hospitals and the other professions involved. He urged that any plan adopted be on a contributory basis for people in respect only for what they pay for. An independent non-political Commission is favoured. He regretted that those who could give the public sound information are not doing so. He recommended a broad committee, including all groups in society, to study the whole question and thus help to make available more accurate information to all. Viewpoints are now too narrow because of insufficient interchange of opinion.

A short round table was conducted by Mr. J. S. Williams of Moose Jaw.

Nursing

Miss K. W. Ellis was in there battling for the nurses with her usual vigour. She feared that the old-time nurses, with all their stamina, would go down like nine-pins before the barrage of present demands. They were taught self-discipline and almost everything else but self-protection. Improvement in present day hospital methods and results is due as much to the nurse as to any other factor. Over 70 per cent of the nurses are working more than an eight hour day. It is hoped that this will soon be corrected.

Too many nurses join hospital staffs without a clear understanding respecting hours, sick leave, vacations, laundry, etc. There should always be a clearly drawn-up contract. A desire for clarity on these points is not a "necessary" indication.

As for hospital planning, no exhausted nurse, who has spent her evenings soaking her swollen feet in cold water, but could contribute some good ideas on improving hospital construction. The nurse in charge should always be consulted in planning hospitals.

Miss Grace Giles, director of the Nurse Placement Service, spoke highly of this service and of its value to the hospital. The meeting supported her suggestion of having regional three-weeks' courses to equip nurses for executive positions. Miss R. Resch, instructor of nurses at Yorkton, discussed the contributions of the nurse to hospital public relations, and Mr. E. R. Gaston, technologist at the same hospital, spoke of the work done by the respective societies of the radiological and laboratory technicians.

Pension Plans

Pension plans were considered by R. A. Estall of Winnipeg and Dr. Isman of Regina, both of the Great West Life Assurance Company. Mr. Estall favoured pensions partly for humanitarian reasons as a reward for faithful service, and partly for economic reasons. Pensions eliminated the element of discrimination, lift payments out of the field of charity, create loyalty and greater efficiency, stabilize employment and set up a means of writing off "human machinery". He strongly favoured a contributory basis, thus making pensions a matter of right. After considering many details he urged that plans should only be undertaken after obtaining qualified actuarial advice.

Highlights of the meeting was the dinner tendered by Mayor Peaker and the City of Yorkton to the delegates. A record number attended to hear Premier Douglas who had flown in from Saskatoon (see this issue). Dr. Agnew spoke briefly and the speakers were thanked by Mr. Wynn.

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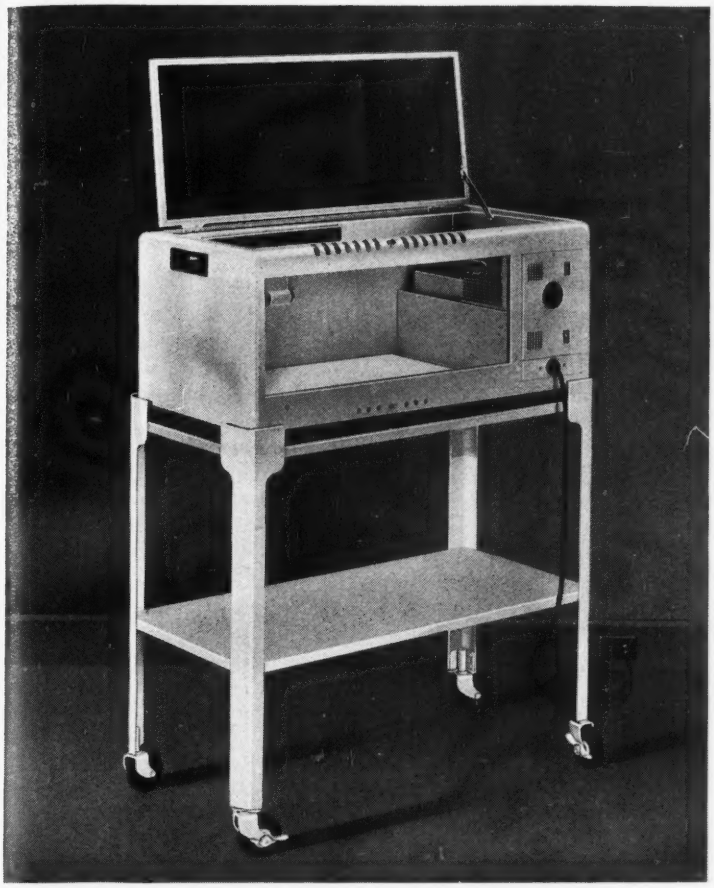

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Alberta Hospitals Approve Minimum Nurse Salaries

Travelling Pool Adopted

A NUMBER of important recommendations or decisions were made at the Calgary meeting of the Associated Hospitals of Alberta in November. Like other western conventions this was a record one despite the last-minute decision to hold the cancelled meeting after all.

Of much significance was the decision to adopt, in part at least, the recommendations of a special committee under Dr. A. C. McGugan respecting minimum salaries for nurses, vacations, sick leave, etc. It was agreed that for general duty nurses the minimum should be $80.00 per month with full maintenance, or $100.00 per month with two meals. Increments amounting to $20.00 per month are to be made over a period of three years. When substituting for a head nurse, $10.00 extra per month will be paid. After the first year there is to be three weeks' sick leave with pay and one month of free hospitalization; also to be three weeks' vacation with pay, in addition to extra time for working on holidays. The object was to establish a floor but not to set a ceiling for specially qualified nurses or those holding staff appointments. More details will be given later.

Also of importance was the recommendation that the principle of having the patient pay one dollar a day for hospitalization be applied to the proposed federal measure. The contributory principle was approved. It was urged also that more be done for the care of the aged and infirm and that the province be requested to assume 50 per cent of the capital cost and annual operation of homes for these people.

It was agreed also to institute a travelling pool for official delegates to equalize the cost of travel for all and thus ensure widespread representation.

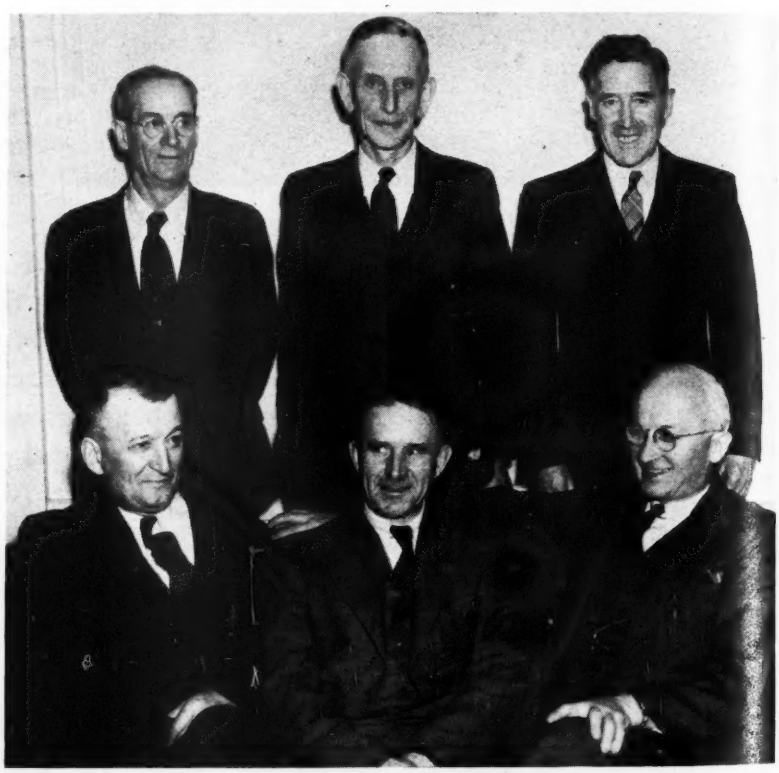
Payments for maternity hospitalization are now paid by the province on a units system calculated on the basis of facilities provided. As costs have gone up considerably in the past few years, an upward revision of the amounts paid is being requested.

In his presidential address, Mr. James Barnes of Calgary stated that the two major difficulties facing hospitals today are the shortage of hospital accommodation and the settlement of differences arising because of excess work placed upon depleted staffs. Because of higher costs for the first few days there is justification for a higher daily charge for the first day or two.

The Association expressed a desire also, to have the hospital accounting system for Alberta brought into line with Dominion Bureau of Statistics requirements. Some simplification is needed, however, for the many small hospitals with no accounting staff other than the matron.

Hon. W. W. Cross, Minister of Health, analyzed the Federal health proposals. To provide the "first stage" benefits, minus visiting nurse service but with surgical care added, would require about 5½ to 6 millions of dollars of new taxation in Alberta. Some 24 to 30 new health units would be needed. The money could be raised by a $10.00 personnal capitation tax on those of 20 years or over, or by a 9 mill property tax. It was his opinion that the transference of taxing authority to the Dominion should not be approved until it is clearly defined where the responsibility for each type of service lies and to what extent.

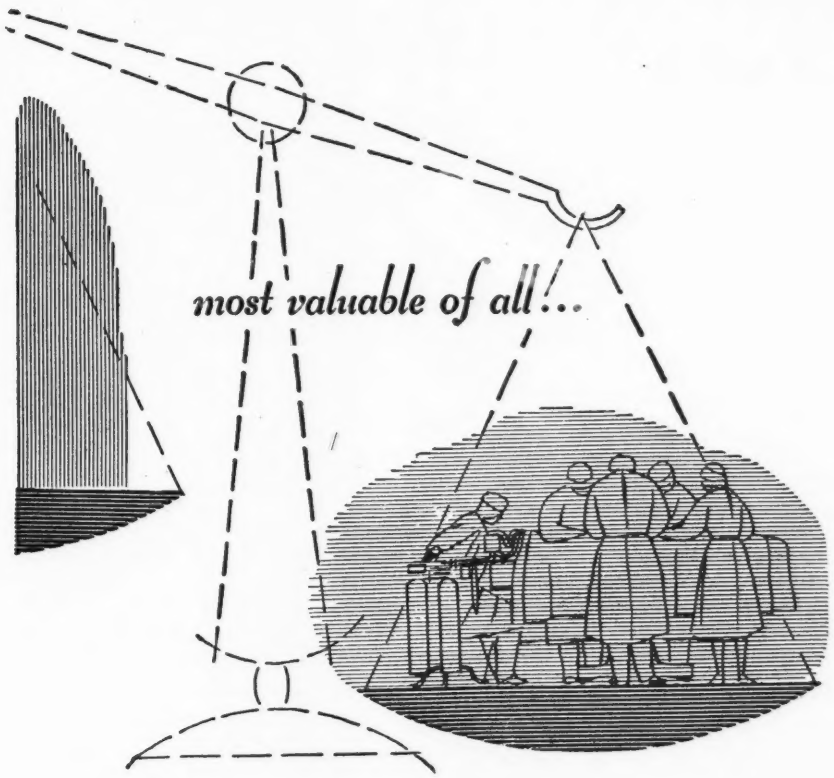
The deputy minister, Dr. M. R. Bow, showed that one in six goes to hospital each year for 9.8 days and



At the Alberta Convention

Standing: G. E. Clay, Paradise Valley; Jos. Cramer, Drumheller; Leonard Wilson, Drumheller.

Seated: Jos. Gallant, Edmonton; James Barnes, Calgary (acting president); Dr. Harvey Agnew, Toronto.



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Hon. W. W. Cross, Minister of Health with Mr. D. W. Clapperton of Calgary.

that there is 1.4 days of hospitalization required for each person. Free maternity care is costing the province half a million dollars yearly but it is money well spent. Thirty-six health nurses are scattered over the province where there is no hospital. A strong tribute was paid to their work. There are 16 health units in operation but about half of these have no medical officer at present.

Infant mortality rates in areas without full-time health units average 40-50 per cent higher than with units. Alberta has the lowest syphilis rate in Canada and the second lowest tuberculosis rate (35 per 100,000). Were it not for the Indians of whom 1 per cent die of tuberculosis each year, the rate would be 40 per cent less.

Other speakers on the program were: Dr. A. F. Anderson and Dr. A. C. McGugan; Dr. Harvey Agnew of the Canadian Hospital Council; Mr. Norman McClellan of Vermilion, chairman of the municipal section; Mr. E. E. Maxwell, supervisor of municipal hospitals; Mr. R. J. Needham of the Calgary Herald, who spoke on Public Relations; Mr. D. W. Clapperton of Calgary who spoke on Health Insurance; Mr. J. M. Wheatley, President of the Alberta Association of Municipal Districts; Mr. J. Gallant and Miss Rogers of Edmonton; Alderman Chalk of Calgary and many others.

Officers Elected

President: A. C. McGugan, M.D., Edmonton; Vice-President: L. C. Wilson, Drumheller; Secretary-Treasurer: Mr. Robert Newstead, Calgary; Executive: Jos. Gallant, Edmonton; C. O. Savage, Innisfail; N. C. McClellan, Vermilion; James Barnes, Calgary.

Municipal Hospitals section: Jos. Cramer, Michichi, (Chairman); Chas. H. Brinton, Vegreville, (Vice-chairman); G. H. Webber, Drumheller; T. M. Allen, Taber; and S. H. Edwards, Bassano.

President-Elect A. C. McGugan, M.D., University Hospital, Edmonton.

Municipalities About Calgary Plan Own Hospitals

The rural municipalities in the Calgary area are seriously considering the erection of a 150 bed hospital in Calgary to serve these rural municipalities. This action has been precipitated by the present overcrowding of the existing hospitals in Calgary.

This project has nothing to do with the proposal in Calgary (approved by the citizens in November) to proceed with the building of a new 600-bed civic institution. Representatives of the rural areas concerned are of the opinion that there will be room for both new hospitals.

An early plebiscite is likely to be taken; approval by 65 per cent is required. A population of approximately 21,000 is in the area being asked to participate and it is estimated that a three-mill rate would permit the hospital to operate on a $1.00 per diem charge basis. The proposal would give the various municipal districts a better type of service than could a number of small hospitals and Calgary would be central to them all. It is proposed to finance the hospital partly by debentures and partly by the anticipated federal loans.

Cost of the 150-bed hospital is estimated at $450,000. This figure is being questioned by some of those familiar with the present day costs of hospital construction. Doubt that a properly equipped fire-proof building of that size with boiler plant, laundry, nurses' residence, etc., could be built today for much less than $4,000—$5,000 a bed, and possibly more was expressed by some.

J. McD. Taylor Memorial

In memory of the late James MacDonald Taylor of Hanna, elected President of the Associated Hospitals of Alberta but unable to complete his term, the Association at its November convention agreed to establish a memorial fund from which ten dollars could be paid annually to the medical student obtaining the highest standing in the final year in medicine at the University of Alberta.

Victory in Our Time

Canada has concluded what might be termed in the vernacular of the war, a beachhead assault on tuberculosis. The early stages of combat are passed, and it is hoped they will remain so. It remains for the heavy guns, the tanks and armoured equipment to finish the battle.

The record of the past few years has shown what can be done by the democratic nations when their resources are mobilized against a common foe. There is every reason to suppose that the same vim and vigor applied to the tuberculosis campaign would bring equally fine results.

The past few decades have seen tremendous advances in regard to treatment of this disease. New surgical procedures, combined with rest, fresh air and good food, have been shown to be invaluable weapons in combatting what used to be known as the White Plague. Modern sanatoria are turning out each year hundreds of persons who have attained a mastery of the disease which enables them to return to full economic independence and a normal life.

—Calgary Albertan

Government Plans Further Elaborated at Manitoba Hospital Convention

DESPITE the late decision, after the lifting of the ban on conventions, to hold a meeting after all, the convention of the Manitoba Hospital Association, November 5 and 6, was said by many to be the best in its history. Attendance was unusually large and many could not get in for the luncheon on the second day. Under the chairmanship of Dr. O. C. Trainor of Winnipeg the program covered a wide range of subjects.

Government Plans

Of particular interest was the discussions of current federal and provincial health proposals by the Honourable Ivan Schultz, K.C., Minister of Health and Public Welfare, and his deputy minister, Dr. F. W. Jackson. Mr. Schultz stated that the Manitoba plans would dovetail in very well with the Federal proposals re health insurance. Together they would make possible more adequate health care than hitherto had been considered possible. The Manitoba plan does not provide hospitalization at public expense, as proposed in the federal plan.

Under any circumstance Manitoba will proceed with its plan. It will enter into the agreement immediately with the federal government, except that it is strongly of the opinion that the provision of visiting nurse service in the "first stage" of the federal plan should be replaced by a diagnostic service.

He stated that it is the intention of the government to make the health units an integrated portion of the hospital system. By so rounding out the functions of the hospital, it does become a true health centre. The success of the plan, however, will depend upon the cooperation of the medical profession and upon that of the hospitals.

Dr. F. W. Jackson stated that during the past year five new hospital districts had been established, sites for 76 rural medical-nursing units had been chosen, basic designs for general hospitals had been developed, plans for one 30-bed hospital (Altona) had ben approved and one diagnostic unit was about to be established. They are still revising standards and plans for local hospitals in an effort to reduce construction and operating costs.

It was a good meeting, to judge by the expressions of President O. C. Trainor and the Hon. Ivan Schultz.

Secretary Ernie Gagnon hears a few things from Vice-President L. W. Lethbridge of Portage la Prairie.

Treasurer W. R. Bell of Souris gets some tips from Judge Milton George, Morden.

Miss Christina Macleod of Brandon and the Hon. Robert Hawkins.

The Government would like to see local health units housed in any new or remodelled hospital. It is hoping, also, to have the offices of the local doctors in these hospitals, thus doing away with unnecessary duplication of equipment, always having a doctor available and helping to make the hospital a health centre. Remodelling will be proceded with as soon as possible. The rural medical-nursing units in an area should be operated as branches of the district hospital. Not only would this do away with duplication, but it would increase efficiency and would promote flexibility in staffing and general administration.

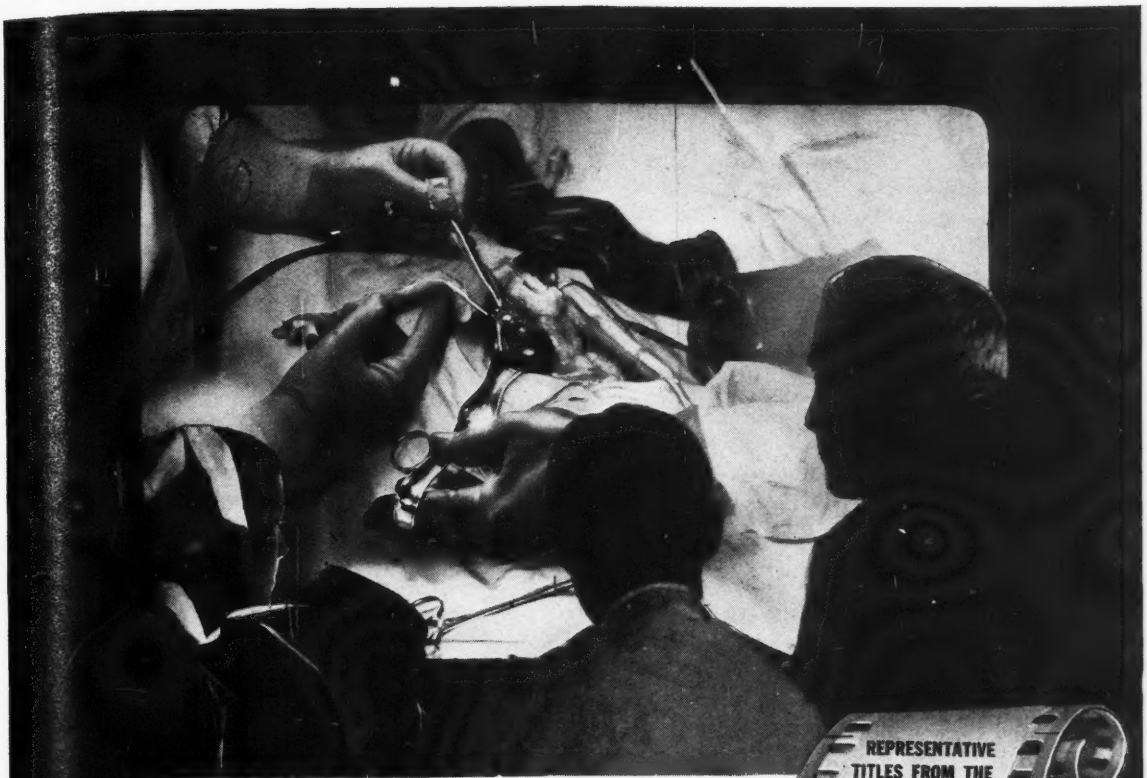
One difficulty to be overcome in this program is the shortage of nurses. Some one hundred will be needed to staff the health units alone and, altogether, some 250-300 more will be needed in the Health Department.

Construction

Dr. A. F. Menzies of Morden brought out some new angles with respect to rural hospital construction. He discussed particularly the importance of calling in a sanitary engineer to advise respecting adequate water supply and sewage disposal systems. We hope to publish this address shortly.

Women's Aids to Organize

Mrs. Milton George spoke of the importance of having a well-organized women's auxiliary in every hospital. As a result of her address and the subsequent discussion, the Association voted to sponsor the setting up of a provincial aids association as has been done in several other provinces. Dr. Gerald Williams pointed out that now is the time to enlist the



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- THORACOPLASTY
- CANCER OF THE FEMALE BREAST
- INGUINAL HERNIA
- SURGERY OF THE BILIARY TRACT
- SUBTOTAL GASTRECTOMY
- ABDOMINO-PERINEAL RESECTION
- CAESAREAN SECTION, DELIVERY OF QUADRUPLETS
- VAGINAL HYSTERECTOMY
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- SURGICAL ANATOMY

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support of many women hitherto engaged in various war activities.

Affiliations

Student nurse affiliations elicited much discussion. Miss K. Ruane, superintendent of nurses at the Children's Hospital, Winnipeg, held that teaching, housing and recreational facilities should all be considered. Affiliation is a cooperative effort and it is more satisfactory to all parties concerned if a written agreement be drawn up. Where affiliations are for short periods, the frequent repetition of lectures becomes quite a problem.

Miss Nixon of Souris would like to see more lectures given during affiliation and more clinical experience with less routine uninteresting work. Considering the experience gained, some affiliation periods are unnecessarily long. Dr. Dougald McIntyre of the Municipal Hospitals would like to see more effort made to fully immunize students before sending them to the communicable diseases hospital. Mrs. Pearson of Dauphin suggested that, in view of the difficulty of arranging affiliations in some cases, there might be a broad general rotation of student nurses between hospitals.

"Current Issues before Hospitals" were reviewed by Dr. Harvey Agnew of the Canadian Hospital Council. Much discussion took place with respect to the proposed civilian blood donor service to be set up by the Canadian Red Cross Society. By a strong majority the delegates expressed a willingness to waive a service charge to cover incidental expenses, although Miss Christine MacLeod of Brandon urged that hospitals acting as distributing centres be reimbursed for the necessary costs associated with doing so.

M. H. S. A.

The Manitoba Hospital Service Association now has some 190,000 participants, stated Mr. P. W. Dawson, the Associate Director. He expressed some concern that certain hospitals had so increased their "going rate" that they were embittering some municipal leaders. Some had raised rates enough to finance various capital improvements and one small hospital had raised its ward rate above its semi-private rate. He referred to the present proposal of the Manitoba Pool Elevators to devote 20 per cent of its 1944-45 funds now in hand to help hospital expansion as a war memorial effort and feared that this action might be affected by these rising rates. He urged an all-inclusive rate and suggested that now is a good time to get new, young and vigorous blood on hospital boards.

Dr. Trainor's thoughtful Presidential Address appears in this issue. It is hoped also to publish, among others, Miss Frances Waugh's outline of the new registration procedures for practical nurses and the plans being developed for instructional work. Miss MacLeod and others spoke of the Canadian Hospital Council meeting at Hamilton this autumn; the convention agreed to empower the executive to take whatever action is necessary to raise additional funds for the reorganized Canadian Hospital Council and for the work of the M. H. A.

Banquet speaker was Col. R. S. Malone, O.B.E., public relations officer of the Canadian Army and personal liaison officer to General Montgomery. Present in Sicily and Italy, in charge of press releases on D-Day, into Paris and also Tokyo before the soldiers themselves got in, and present when the Japs surrendered on the "Missouri", he had a fund of interesting experiences and some character-revealing tales of "Monty" and others.

Above—Peter Cornes and Donald M. Cox, Winnipeg.

Above—F. W. L. Judge and Grant McLeod, Winnipeg.

Above—Dr. Dougald McIntyre and Dr. J. R. Thompson, Winnipeg.

Above—Dr. G. S. Williams and B. P. Warne, Winnipeg.

Administration Course

On the suggestion of Mr. Donald Cox of the Municipal Hospitals, Winnipeg, it was agreed that the M.H.A. should explore the possibility of having a refresher course on administrative topics, possibly just before the annual meeting next autumn. This might be undertaken in conjunction with other organizations and include a special day for trustees.

Officers

Hon. President: Honourable Ivan Schultz, K.C.

President: Owen C. Trainor, M.D., Winnipeg.

Vice-Presidents: Miss L. W. Lethbridge, R.N., Portage La Prairie; Judge J. M. George, K.C., Morden.

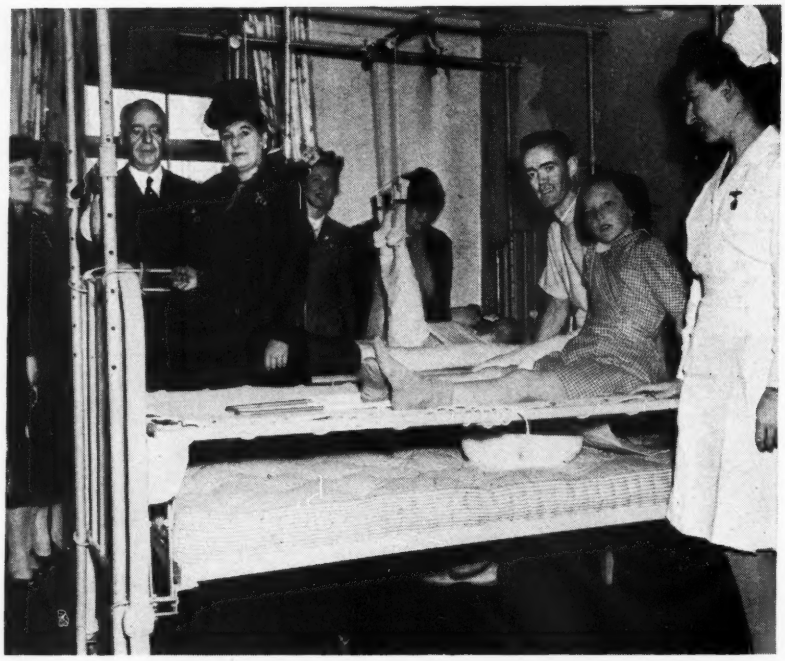
Secretary: Ernest Gagnon, St. Boniface.

Treasurer: R. W. Bell, Souris.

Directors: Miss Christina MacLeod, R.N., Brandon; Harry Coppinger, M.D., Winnipeg.

X-ray Department Opened

The official opening of the $7,000 x-ray department at Grace Salvation Army Hospital, Ottawa, took place November 8th in the presence of a small group of Salvation Army officers and supporters.



Presentation Made to Halifax Hospital

The presentation of a cheque for $375.00, covering the cost of equipment in the fracture room at the Children's Hospital, Halifax, N.S., took place on October 19th, with Mrs. M. B. Fineberg presenting the cheque on behalf of the Ladies' Auxiliary of the B'nai Hebrew Service Club.

The equipment donated by the society consisted of a fracture bed, two overhead bed frames for fracture extension work and three x-ray illuminators. The equipment was demonstrated with children acting as models. It is the plan of the Auxiliary to supply more fracture equipment as time goes on. The room which the Auxiliary has adopted is to have a plaque on the door and this room will be open to its members at any time for visiting purposes.

Present at the demonstration and presentation were members of the hospital board, and staff, and the executive of the donating club.

Presentation Made to Dr. Stephens

Dr. George F. Stephens, superintendent of the Royal Victoria Hospital, whose recent illness brought about his much-regretted retirement as president of the Canadian Hospital Council, has been presented with a sterling silver salver on behalf of the Catholic hospital sisters. The presentation was made by Rev. Sister M. Berthe Dorais, president of the Catholic Hospital Council of Canada.

The inscription on the salver reads: "Presented to Dr. George F. Stephens in grateful appreciation by the Sisters of the Catholic Hospitals of Canada, 1945".

Inter-Plan Benefits

Subscribers of 33 Blue Cross plans, totalling about 10,000,000 of the 18,800,000 membership, are now participating in the inter-plan service benefits agreement, according to reports to the Hospital Service Plan Commission. The agreement assures a member of one plan the free service benefits of the Blue Cross plans serving any area in which he might need hospitalization — replacing the practice of daily cash allowances when Blue Cross members are hospitalized away from home. Generally speaking, plans report that the agreement is working with little or no difficulty.

—*Hospitals.*

Hospital of the Future

(Concluded from page 27)

role of a brake on the wheel of progress.

To do these things effectively we must seek *active partnership with governments.* To such partnership we can contribute a knowledge, based on years of experience, not obtained outside our ranks.

I have attempted to sketch in rough and very incomplete outline some of the considerations which should guide the voluntary hospitals in the future. These are considerations which will fall within the purview of hospital organizations. It would be manifest folly for the individual hospital to attempt this programme. We must stand united if we hope to pull our full weight in the service of humanity.

The Necessity of Organization

In the light of these considerations, the real importance of a strong and well-integrated organization of the voluntary hospitals is clearly apparent. The necessity of organization on regional, provincial and federal bases, with adequate provision for liaison and integration of objectives, should be beyond controversy. The individual hospital must recognize that its own future welfare is indissolubly linked with the successful functioning of hospital organization. Provided this objective can be attained, one can see no reason why the voluntary hospital should fail to retain its present position and, as well, achieve a standard of efficiency and service as yet undreamed of.

R.C.A.F. Buildings for Mental Patients

The Saskatchewan government is making arrangements to rent from the Dominion Government approximately 30 buildings at the R.C.A.F. airport at Weyburn, to be used as temporary quarters for mentally ill people from the overcrowded mental hospital at Weyburn.

Approximately 700 patients will be moved from the hospital proper to the new quarters. As repairs on the individual buildings are completed, about 50 patients at a time will be moved from the main hospital.

Here and There

By the Editor

Recent Distinguished Visitors

AMONG the distinguished visitors who have come to Canada in recent weeks to visit our hospitals have been Dr. O. Rofas Avendano, professor of surgery of the University of Mexico, and Miss Elena Rueda Quijano, director of the Children's Hospital in Mexico City. This magnificent new hospital was one of those illustrated in *The Canadian Hospital* a couple of years ago. Both Dr. Avendano and Miss Quijano extend a warm invitation to Canadian hospital people to visit their great hospital centre in Mexico City and their fine system of up-to-date hospitals throughout the country.

Another distinguished guest was Lieut.-Col. Le Soeuf of Perth, West Australia, who is spending three months on this continent studying hospital construction and procedures at the request of his government. Lieut.-Col. Le Soeuf was taken prisoner at Crete in 1940 and spent the next four years in various prison camps in Germany. Fortunately, he was permitted to practice surgery and, by his achievements gained some begrudging respect from the Nazis. He strongly disagrees with any statements that the Nazis gave their prisoners good treatment. A ration of 1400 calories a day would have been utterly inadequate had it not been for the Red Cross parcels. They starved when these parcels were cut off. The Germans steadily violated the Geneva conventions throughout the war. A graph of the treatment of British prisoners showed some improvement only after German defeats and after they themselves had lost many men as prisoners.

* * *

No Balm in Gilead?

These hospital associations have no consideration for their hardworked treasurers—no feelin' from the heart whatsoever. Now take Manitoba for instance. Just because R. W. Bell is a banker down Souris way and accustomed to salting away the huge rolls of greenbacks that those farmers tug out of their jeans, the Association has kept him as Treasurer since the far reaches of living memory. Year by year the records grow—and so does the package under his arm.

This year he rebelled. In return for his skill in keeping from them the true state of their books, surely his colleagues could provide him with some sort of case for these priceless records. With tears in his voice he held up the tattered wrapping paper and old binder twine, the same ones, he admitted, which he had used for years. What with Ernie Gagnon opening so many new accounts for card exhibits and with hitchhiking up to Winnipeg not being what it used to be, surely, we ask you, something could be done for the faithful keeper of the shekels.

His appeal did not fall on stony hearts. President Trainor will look into this personally and one big-hearted superintendent from a neighboring city indignantly affirmed that she would get the Treasurer a briefcase herself if the Association didn't. As this lassie betrays her Scottish upbringing every time she speaks (which is not a rarity), we realize how deeply she must have been moved. At any rate we feel safe in portraying Mr. Bell as we expect to see him striding to the platform at the next convention.

* * *

Sir Charles Maitland

A third distinguished guest was Sir Charles T. Maitland who visited in the Toronto area during the week of November 5th as a representative of the British Ministry of Health. A career in administrative medicine is the background for Dr. Maitland's present assignment in connection with the construction of the British National Hospital System under the comprehensive scheme of medical care which is to be provided for the British people. Dr. Maitland has lectured for many years in public health at St. Thomas's. During the war, he was the Principal Regional Medical Officer in the Birmingham are and was responsible for the system of emergency medical services which sustained the British people through the devastation occasioned by aerial warfare. He was particularly interested in our method of caring for the chronic sick and paid special visits to the Queen Elizabeth Hospital, the Mercy Hospital and the new Runnymede Hospital. He holds the view that our large public general hospitals should be for acute treatment and that we must develop an adequate system of convalescent, recovery and special hospitals for the treatment of those who do not need the expensive general hospital care which they very frequently receive at the present time, for want of more suitable accommodation. All who came in contact with Dr. Maitland found his wide comprehension and quick intellect a source of pleasure and inspiration.

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If she dug the film out of the cassette with her fingernail, she might scratch or soil the intensifying screen. Damage to the protective coating of the screen causes faulty radiographs.

Care should also be taken when inserting the film to avoid marring the screen with sharp edges of film. And when loading or unloading cassettes, it is well to keep clear of processing tanks. Developer splashes cause indelible discolorations that absorb fluorescence . . . resulting in spotty radiographs.

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* Colebrook, L. (1933) *J. Obstet. & Gynaec.*, **40**, 977.

Against such hazards—which have their parallel in the operating theatre—an obvious precaution, additional to the use of face masks, is to apply a *persistent* antiseptic—one that will form a durable barrier to infection on the skin or gloved hands.

Controlled experiments have shown that 30% "Dettol" provides such a protective covering for over two hours.

Further experiments, laboratory and clinical, have demonstrated that "Dettol" at full strength is non-toxic and non-irritant—and yet rapidly lethal to a diversity of pathogenic bacteria even in high dilution, and even in the presence of blood and other organic contaminants.

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M.10a

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The physician's explanation of why oxygen is being prescribed and what beneficial effects it will have goes far toward gaining the patient's confidence and calming any fears he or members of his family may have.

But this confidence must be maintained. Therefore it is important for the nurse — by showing that she is thoroughly familiar with handling the apparatus and with the treatment in general — to continue to inspire this confidence.

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British Labour Government to Replace Health Insurance by State Medicine Plan

PRESS announcements would seem to indicate that the Labour Government in Great Britain plans to abolish the present plan of health insurance for one of out-and-out state medicine. The private practice of medicine would be discontinued except for a few individuals who would not be permitted to practise under the state plan. It is proposed also to take over all the voluntary hospitals large and small, "on terms which will satisfy the nation's sense of equity". This program will replace that of the Churchill Government and it is significant that those Labour members in the House who have had long experience with the problems of providing health care were excluded from posts of responsibility in defining health policies.

Patient Comes First

A committee was appointed and told to prepare the new plan strictly on the basis of the patient's welfare and where the interests of the patient and doctor conflict the doctor must give way. The plan provides that no one need pay a farthing out of his own pocket for medical care and the services of specialists and the greatest surgeons will be available freely and on exactly the same terms to all.

The central authority will be the ministry of health, which would take over every service dealing directly with health and medicine. The whole country would be divided into regions and each region would in turn be subdivided into divisions with populations of from 100,000 to 250,000.

Each division would be provided with a general hospital of from 600 to 1,200 beds equipped to treat all except infectious and mental cases. A wide variety of special and private hospitals now existing would be eliminated but a certain amount of specialization would be encouraged in that hospitals would be co-ordinated in groups of five or six, one of which would have a staff specially trained in eye diseases, another in skin diseases and so on. In each region would be a sort of super-hospital specially staffed and equipped for rare or delicate surgical operations or for treatment of diseases not usually met with in normal practice.

50 Doctors to Every Hospital

There would be no more hospitals run by churches, charitable organizations or private groups. Since the country now has only about half the hospital space needed, many new ones will have to be built while some existing hospitals which do not come up to standard will be scrapped. Each hospital should have a permanent staff of about 50 doctors.

There would be a divisional health centre close by, but not necessarily attached to each hospital, and a local health centre in each neighborhood. Primarily these would be doctors' offices and consulting rooms, but a divisional health centre would include a laboratory with a clinical pathologist in charge, x-rays, facilities for medical research and specialists who would serve the whole division, treating cases referred to them from the local health centre.

Each local centre, not less than four to a division and in the rural divisions more, would be staffed with from eight to twelve general practitioners. The local health centre would also have a staff of mid-wives, home nurses, home helpers, health visitors and social welfare workers. Patients could choose their own doctor from those on the staff and could draw on specialists at divisional health services and hospitals when needed.

Subject to Direction

The committee proposes to organize the medical profession on a national full-time salaried, pensionable basis. They insist also that a doctor must be subjected to direction to the district where he is most needed and that a doctor serving the health scheme must have no private patients. They are willing to concede the doctor the privilege of purely private practice if he can persuade patients to pay him for services to which they are entitled free of charge from the government agency.

Home Nursing Service

Complete home nursing service will be set up in conjunction with each health centre, while the nurses' training course, admittedly backward, and the nurses' working conditions in hospitals will be improved. It is proposed to re-organize the mid-wives' service. Each local health centre will have an ante-natal clinic and a staff of home helpers to assist in the home before childbirth as needed and for at least two weeks after confinement without cost.

The scheme would be supported partly by national taxation and partly by local rates. The ministry of health would bear the full cost of all central organizations and would pay a substantial grant to regional committees on the basis of a fixed percentage of its total expenditure on health.

Kingston General Plans 10-year Expansion

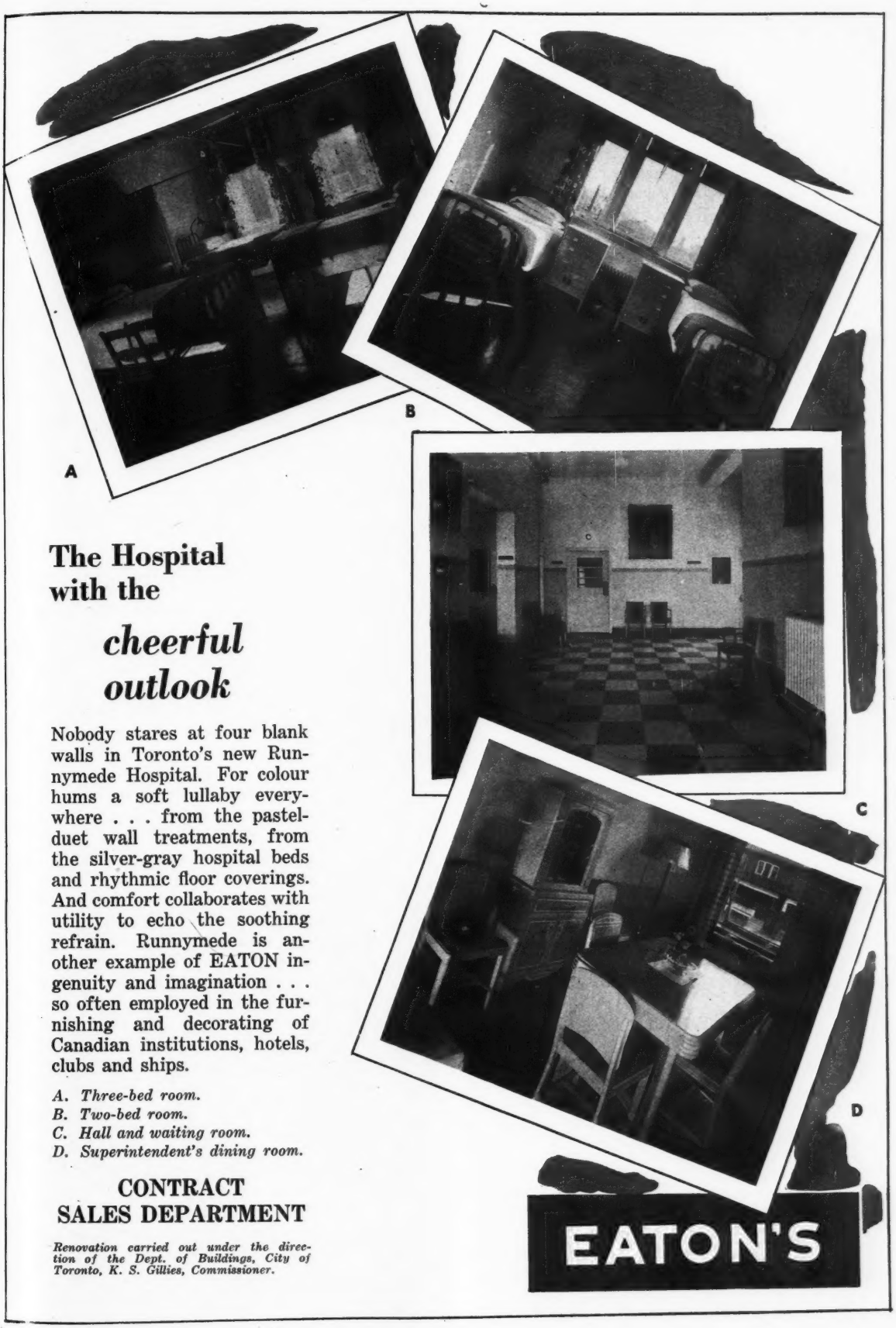
A broad programme of expansion, to be completed within the next ten years, is planned by the Kingston General Hospital. The programme has been initiated with the start of the new Victory Wing, the outside walls of which are now almost up.

The complete plan includes an addition to the Douglas Wing, more quarters for nurses and other changes in the working units of the hospital which will make existing facilities more efficient. It will cost approximately $1,692,000.

The ground floor of the partially-constructed Victory Wing will house the cancer clinic laboratories, photographic rooms, etc. The four upper floors will be patients' rooms, which will be easily converted from semi-private to private rooms. Administration rooms, utility rooms, elevator shafts and other sources of noise will be placed so as to provide the least possible disturbance to patients.

Following the expansion of the nurses' living quarters, which is considered a paramount need, it is proposed to extend the present service wing, where the kitchens and the staff dining rooms are now located.

The Ontario Government has agreed to assist in the cost of this programme by way of Queen's University, whose medical faculty makes use of hospital facilities.



The Hospital with the

cheerful outlook

Nobody stares at four blank walls in Toronto's new Runnymede Hospital. For colour hums a soft lullaby everywhere . . . from the pastel-duet wall treatments, from the silver-gray hospital beds and rhythmic floor coverings. And comfort collaborates with utility to echo the soothing refrain. Runnymede is another example of EATON ingenuity and imagination . . . so often employed in the furnishing and decorating of Canadian institutions, hotels, clubs and ships.

A. Three-bed room.
B. Two-bed room.
C. Hall and waiting room.
D. Superintendent's dining room.

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Renovation carried out under the direction of the Dept. of Buildings, City of Toronto, K. S. Gillies, Commissioner.

EATON'S

Women in French National Life

Thirty-one women were elected to Parliament in the recent general elections in France in which women voted for the first time. Most of the women candidates were heroines of the resistance movements and 14 of them were communists.

For the first time in French history, the women of France have been granted full electoral privileges. For the first time, they are able to take part officially in shaping the destiny of their country, on terms of equality with men. The decree passed by the Algiers Consultative Assembly on April 21, 1944, officially recognized their important role in national life, particularly during World War II, and granted them the suffrage to which they have long been entitled. Although there are still numerous domains in which they have not acquired full privileges, this may be considered one of the final phases in a gradual evolution toward the emancipation of French women.

In general, women have always been considered inferior to men in political, economic, and social life. The Napoleonic Code, promulgated in 1804, translated the tradition into written law. Although single women who had attained their majority enjoyed most civil rights, married women had no legal capacity and were required to obey their husbands' decisions on all questions. This marital protection of a moral and religious nature, usually regulated by the marriage contract, exerted a profound influence on national life. Law and tradition prevented both married and single women from holding directive positions and, since their work was considered inferior to that of men, they were paid only half as much for the same work. Women had many obligations but few privileges.

Strangely enough, although France was one of the few countries in which women were not able to vote, the suffragette movement was always weak and even opposed by many intelligent women. Actually, however, they have always played an important role in national life because from their position behind the scenes, they were able to influence the man in power. They were, moreover, greatly concerned over other problems and, through such organizations as the Society for the Protection of Mothers (1856), the Society for Professional Education of Women (1862), and the more recent National Council of Women, they attempted to better conditions for French mothers and children and working women, and to effect various social and religious reforms, as well as improved education for women.

The law promulgated on July 13, 1907, permitted married women to dispose freely of their own earnings, and in 1921, the family ceased to be a romanesque autocracy, since the father might be deprived of authority over his children. French women who married foreigners after 1927 retained their citizenship, but it was not until 1936 that they were qualified to sue in a civil action.

The first step toward the reorganization of women's education was made possible in 1880 by the institution of government controlled secondary schools for girls. Normal schools preparing women teachers for primary and secondary girls' schools were also established at this time. But it was not until 1924 and 1925 that secondary courses for boys and girls were standardized so that girls could obtain the Bachelor's certificate required for entrance to institutions of higher learning. A few women had been able to take special examinations leading to the Bachelor's certificate and higher degrees, but those degrees were usually not equivalent to those granted to men. In spite of tradition, more and more women completed advanced studies which entitled them to practice a liberal profession, and they continued to excel in artistic fields. In fact, after World War I, French women, in theory, enjoyed many of the same privileges as men, although the consent of the husband was frequently necessary.

Still, women were not eligible to vote, and they could not be elected to public office. It had taken all of thirteen years to bring about even a partial reform in the legal status of married women; the chief virtue of the 1938 reform being that it endowed the courts with authority to settle disputes betwen husbands and wives over professional questions; the legal rights of married women were still essentially dependent on the marriage contract.

One of the first acts of the Vichy government was to degrade women to the position of servants in the home. In 1940, women were forbidden to hold government positions unless they had previously held teaching contracts or their husbands were unable to support their families. Young girls were discouraged from enrolling in university courses and impressed with the obligations of preparing for marriage and motherhood. By 1942, however, Vichy was obliged to make drastic changes in its policy in order to recruit women workers to replace men deported to Germany. Women were admitted to municipal councils in communities of less than 2,000 inhabitants, and a law passed in November, 1942, decreed that the marriage contract should continue to be strictly observed but that women could be empowered to transact legal business in the absence, or on the refusal to act, of their husbands.

By this time, women were already participating actively in resistance work. At least 360,000 of them were members of resistance groups, and countless others gave anonymous help. For the most part, their leaders were women who had previously taken part in civic affairs and feminist organizations such as the anti-fascist groups. Women acted as liaison agents, nurses and even section heads; they took part in parachute missions, fought valiantly in guerilla troops and the French Forces of the Interior, and some of them held positions of military responsibility. They frustrated German regulations and efforts to recruit slave labor, sheltered Allied fighters and racial victims, and, themselves, published numerous clandestine newspapers and pamphlets. About 60,000 of them were tortured and deported to Germany, and some were murdered

(Concluded on page 74)

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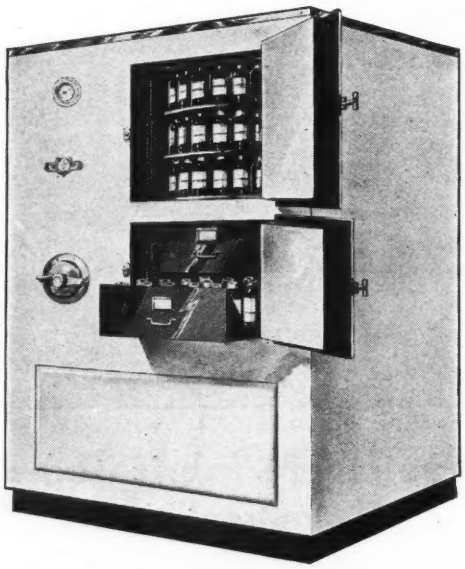

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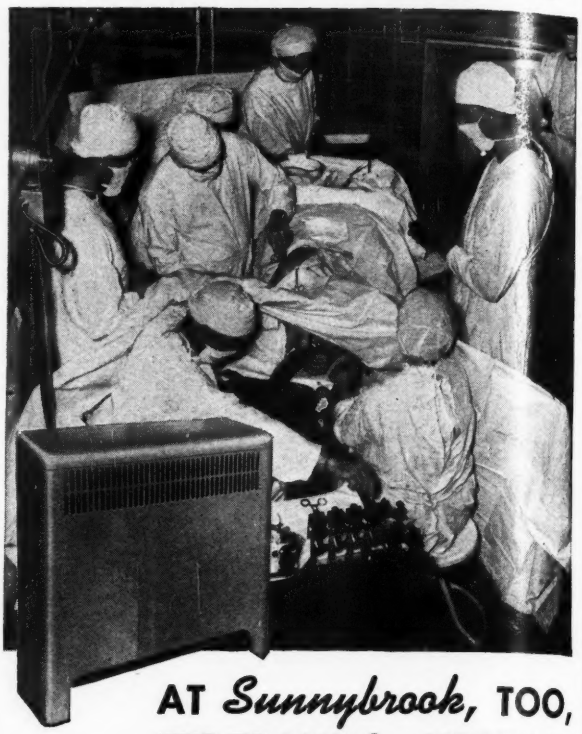

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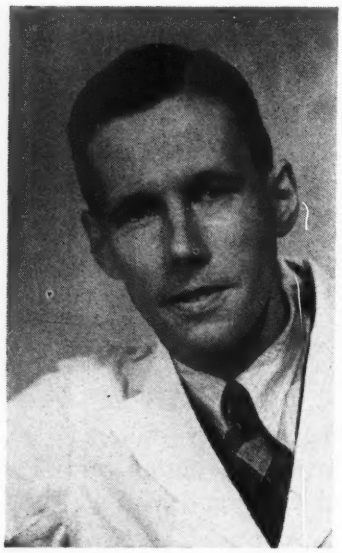
Hospital Photographer Resigns

Mr. H. S. (Peter) Hayden, F.R.P.S., who has been in charge of the Photographic Department of the Montreal Neurological Institute under the Directorship of Dr. Wilder G. Penfield, has resigned his position to enter the private practice of medical photography in Montreal.



Mr. Peter Hayden

Born in London, England, Peter Hayden came to McGill in 1933 at the request of Dr. Penfield for the purpose of developing new methods of photographing surgical procedure.

In 1935, Hayden was awarded the Fellowship of the Royal Photographic Society of Great Britain, for a thesis describing his new technique for obtaining clear, full-scale photographs of surgical operations. This method is based upon a surface reflecting mirror in the operating room, and a long focus telephoto lens and camera outside of the sterile field. The ingenuity of this invention and the results achieved by it have been widely acclaimed.

U.S. Service Equipment Available to Hospitals

Army and Navy equipment worth billions of dollars is being earmarked for immediate post-war service in hospitals and schools of the Nation's poorer communities. Robert A. Hurley, member of the Surplus Property Board, revealed September 17 that the finishing touches are being put on a vast program to distribute, virtually cost free, much of the material and equipment left over from the war.

Everything from complete hospitals to the latest athletic equipment will be available to counties, schools, charities, labor unions and other non-profit institutions that can show: (1) That they could not afford to buy such equipment through normal trade channels. (2) That they will provide necessary building and staff to use the material correctly.

Recipients of military surpluses under this program will be asked to pay only a nominal sum, to cover the cost of shipping. "Any community", Hurley explained, "that cannot afford adequate hospital facilities will be able to get a complete hospital for the cost of the building and the staff." "Any school," he continued, "can have equipment for health clinic, including X-ray machines, if the school board could not afford to buy the equipment, but can provide a doctor . . . ."

G. H. Cole in "PM"

Minimum Wage Legislation Supported by Deputy

Speaking before the Saskatchewan Hospital Association, Mr. J. H. Williams, Deputy Minister of Labour, strongly supported this type of legislation. Such acts as:

1. Protect workers, especially young women.
2. Bringing employers to a realization of their responsibilities.
3. Achieve results without strikes and maintain peace.
4. Do away with sweating and exploitation.
5. Avoid undercutting of prices.
6. Keep trained workers from moving and reduce fluctuation in industry.

Manitoba and British Columbia were the first to pass such acts for women in 1918. Saskatchewan and Quebec did so in 1919 and Nova Scotia and Ontario in the following year. Alberta legislation was passed in 1922. British Columbia passed a minimum wage act for men in 1925.

In Saskatchewan no eight-hour day has been set for any industry. A 48 hour week has been stipulated but this is primarily for establishing the weekly wage. Overtime is allowed but overtime wages have not been set.

CAMSI Meets in Winnipeg

The Canadian Association of Medical Students and Interns (CAMSI) met in Winnipeg early in November. This was the first occasion on which the annual meeting had been held in Winnipeg. Eight medical schools were represented.

Mr. Harold Davies, president of the organization stated, "We are pursuing a common interest and are making for good citizenship by a study of national health projects and by seeking communication between medical schools by correspondence and by an exchange of journals." A post-war reorganization was one of the major considerations before the gathering. Continuity of policy is a problem in this organization with its constantly changing membership and officers. Closer relationship to the Canadian Medical Association was urged by Dr. W. W. Grant.

The Dalhousie committee had made a study of the economic position of medical students. This report, presented by Charles S. Wright, Sr., revealed that 30 per cent of students come from homes engaged in professional work; a like number come from the trade and commerce group. Some 85 per cent of the students come from homes with an annual income of less than $5,000, with 41 per cent of this group in the $1,000-$2,500 range. Considering fees and living expenses, McGill appears to be the most expensive medical school to attend, with Toronto second and Dalhousie third. Alberta and Manitoba are the least costly.

Dr. F. W. Jackson, Deputy Minister of Health and Public Welfare for Manitoba, outlined Manitoba's health programme at one of the sessions. Other speakers were President A. W. Trueman of the University of Manitoba, Dr. I. M. Thompson, Col. C. E. Corrigan, Mr. Arthur Harvey, Mr. Dave Robertson and others. Various clinics and hospital demonstrations were arranged and a banquet and dance were part of the busy program.

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Under analgesia, the patient loses the feeling of fear while the sense of pain is greatly minimized and frequently eliminated, but consciousness is retained. In obstetrical cases, the patient is able to offer better cooperation.

Patients who are examined under local anesthesia have freely acknowledged that instrumentation under analgesia is more comfortable while patients with severe pathologic conditions have frequently expressed their gratitude for the use of analgesia apparatus, which has helped them lose their dread of cystoscopic procedures.

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In 1944, 21,033 cases of gonorrhoea and 15,911 cases of syphilis were reported by provincial health departments to the Dominion Bureau of Statistics. The ratio of gonorrhoea to total syphilis was, therefore, 1.3 to 1.

Cases of Venereal Disease Infection Reported by Provincial Health Departments to the Dominion Bureau of Statistics, 1944.

	Gonorrhoea	Syphilis	Ratio Gonorrhoea Syphilis
P. E. I.	20	35	0.6
Nova Scotia	1,663	496	3.3
New Brunswick	913	573	1.6
Quebec	3,936	6,539	0.6
Ontario	7,317	5,225	1.4
Manitoba	1,737	663	2.6
Saskatchewan	1,123	360	3.1
Alberta	1,348	750	1.8
British Columbia	2,976	1,270	2.3
Canada	21,033	15,911	1.3

The experience of the three Armed Forces in Canada from 1940 to 1944 reveals that the ratio of gonorrhoea to total syphilis in Canada for that period was approximately 6 to 1. It is apparent, therefore, that the reporting of gonorrhoea by physicians in Canada is very inadequate. There is reason to suspect that syphilis is not being reported completely.

We know definitely that 15,911 cases of syphilis came to attention. Admitting that the ratio of gonorrhoea to syphilis was 6 to 1, it is estimated that in 1944 there were at least 90,000 cases of gonorrhoea in Canada. Of these, only 21,033 were reported by physicians.

The incidence rate of syphilis in Canada is exceedingly high. In 1944 the syphilis rate for Canada was 135 per 100,000 per annum. In 1942, the syphilis rate for Sweden was 7 per 100,000 per annum and the rate for Norway was 38 per 100,000 per annum and the rate for Denmark was 23 per 100,000 per annum. These are three countries which have maintained reliable venereal disease statistics over a period of years.

Mr. Malcolm Beaton, radiologist at the Sherbrooke General Hospital, Sherbrooke, Quebec, died on November 2nd after a short illness.

Headache and disease are not far apart. Headache in persons unaccustomed to it is a serious symptom.—*Hughlings Jackson.*

Women in France

(Concluded from page 62)

by the Gestapo or died a slow death in prison camps.

And in England, as early as 1940, women's volunteer services were organized for the army, navy, and air forces. The French WAC organization had in February, 1944, a membership of 4,000 volunteers, among them the widely-known journalist, Eve Curie. Women occupied important posts in the Free French administration of North Africa, and when the French Committee of National Liberation in Algiers was organized in 1943, Madame Andree Simard became the first French woman appointed to a national assembly.

On April 21, 1944, women were granted full electoral privileges. As the equals of men, they are entitled to vote and to be elected to any public office. Twelve women were appointed to the Paris Consultative Assembly by their resistance organizations or by political parties.

Almost without exception, French women have accepted their new responsibilties seriously, and in every walk of life they have shown themselves eager to learn and to act in the best interests of the people as a whole. They know, through their votes (which outnumber those of men in certain regions), that they will be able to hasten certain long-desired reforms in public health, working conditions and wages, food distribution, education, planned housing, and social legislation; they are even more interested in their opportunity to participate for the first time in the formulation of over-all government policies.

The many women's organizations which grew out of resistance activities and after the liberation are chiefly interested in promoting the social and political education of women all over France. Some of them have conflicting political platforms, but their fundamental aims are identical, and a central administration organization has been very successful in co-ordinating the efforts and activities of various groups. Women also hold responsible posts in trade unions whose strength has increased considerably since the war.

There can be little doubt that women will have a large share in the political, economic and social reconstruction of France. Today, they are represented in the National Constituent Assembly and in almost every departmental and municipal government, even as mayors. Fifty per cent of the French primary teachers and forty-five per cent of the secondary teachers in France are women, and more and more of them are appointed to university posts. They make up one-fourth of the medical profession, one-fifth of the dentists, and one-fifth of the pharmacists. Five per cent of the lawyers are women. Women make up at least half of the university student enrolment.

The complete emancipation of French women will remain a question of tradition for many years, as in other modern countries, but the evolution toward equality of rights in France has been greatly accelerated because of the tremendous activity of women during the war.

Service d'Information Francais.

Medicine: the art of coming to a conclusion on insufficient evidence.—*Anonymous.*

"General Practitioner" Service

A disturbing note is struck by the announcement, or rather the intimation that the first step will be "general practitioner" service—to be followed by increase in hospital service, specialized service and so on . . .

To us, "general parctitioner service" sounds very much like a panel system such as has obtained in Great Britain. The panel system is a pernicious and inefficient system of medical practice that we hope we shall never see in Canada. And once we get it, we shall find it next to impossible to obtain a good medical service . . . .

The service, if it is to be worth having, if it is to lessen the incidence of disease, to anticipate and prevent it, and to give adequate treatment, must be complete. It must include surgical and specialist care as much and as inevitably, as it includes general practitioner service, whatever that phrase may mean. In this day and age, the general practitioner must be allowed and equipped—even compelled—to give adequate service, including hospital care, X-rays, etc.—and anything less will lead to bad and inadequate medical service. If this thing has to be done in stages, the stages should be so arranged as, first, to give relief where it is most needed; second, to lead to the best kind of medical service; third, to lead to the lessening and shortening and preventing of loss of health and time due to illness . . . .

The first step should be extension and increase of hospital facilities, diagnostic facilities, etc., which should be available to all, and which should be provided for the use of the medical man, specialist, general practitioner, or whatnot. This is the first need. Its lack is one of the greatest of reasons why illness causes so heavy and intolerable a burden. The cost to the sick man of general practitioner service is the smallest of his burdens, and is not what makes his illness so hard to pay for. It is hospital care, now regarded as an essential in almost any illness, the cost of specialized care, of operations, etc. These are the things which the average man cannot afford—and we shall not lighten his burden to any appreciable extent by such a plan as is being suggested. As a profession, we should set our face firmly against any such proposal.

Editorial, Bulletin of the Vancouver Medical Association.

Plan 100-bed Hospital for Colchester County

Approval was expressed at a recent meeting of the Colchester County Hospital Trust of the building of a new 100-bed hospital, to be known as the "Colchester Memorial Hospital", in memory of Colchester citizens who gave their lives in the recent conflict.

The present hospital is badly overcrowded, and experts have stated that the cost of an entirely new building would be very little more than the cost of adding 100 beds to the existing institution. When the new hospital is built the necessary provision will be made for future expansion.

Standard Nomenclature

(Concluded from page 34)

Now let us take time to study the following disease and operation codes in order to illustrate the above principles:

Disease	Site Cause	Operation	Site Procedure
Abscess of breast	190 — 100.2	Incision and drainage of breast	190 — 02
Cystic breast	190 — 6X8	Mastectomy	190 — 10
		Excision of lesion	190 — 11
		Simple mastectomy	190 — 12
		Partial mastectomy	190 — 13
		Radical mastectomy	190 — 14

Explanation: The anatomical site in our first example is the breast, 190—; (the type of operative procedure "incision" is represented by the figure); the subdivision of this general procedure which denotes drainage is 02. Therefore the dual code 190—02 implies incision of breast with drainage. Similarly mastectomy is classified as "excision of breast" 190—10. The (1) denotes "excision", —11, would imply excision of a lesion; —12 excision of an organ; —13 partial excision of an organ and —14 radical excision. Therefore a radical mastectomy would be coded 190—14.

These examples have been necessarily brief. However, I hope that they have been detailed enough to make clear the necessity for, and the ease of use of the *Standard Nomenclature.*

Summary

To summarize—in *Standard Nomenclature of Disease and Operations* the following facts are most apparent:

1. The first half of the code number (before dash) indicates the *site;*

2. The second half of the code number (after dash) indicates *cause* of disease in the disease classification and type of *procedure* in the operation classification;

3. The system of numerical coding of operations is adopted from that used in *"Standard Nomenclature of Disease"* and, therefore, the indexing of disease and operations goes hand in hand;

4. The numerical coding of disease and operation affords a brief description and is therefore, in many instances, a better description of the disease or operation than the commonly accepted name for it.

Conclusion

Thus the compilers of *Standard Nomenclature of Disease and Operations* have succeeded in giving us a simple but comprehensive classification. Since it eliminates personal variations introduced by individuals, promotes uniformity in terminology, stimulates clear thinking and is of great value in all fields of medical research, it is a standard nomenclature and to date *"The Standard".*

Gets Moncton Appointment

Dr. Ian MacLennan has been appointed pathologist to the Moncton City Hospital. Dr. MacLennan comes from Campbellton, N.B. The appointment of an anaesthetist is under consideration by the Board of the hospital.

Appalling Health Conditions Revealed in Poland

Disease slowly but surely is accomplishing what the Nazi hordes failed to do—exterminating Poland.

Each month 10,000 Poles die from Tuberculosis. Whole villages have been wiped out and the disease still is spreading. Out of a total population of 25,000,000, more than 1,200,000 cases were reported betwent last January and August alone.

In the same period, 22,000 cases of abdominal typhus and 13,000 cases of spotted typhus were reported.

Need Penicillin

Every month 400,000 cases of syphilis are reported. Fifteen per cent of the persons entering Poland from Germany and Nazi concentration camps are syphilitic. In addition, 50,000 cases of gonorrhoea are reported monthly.

Polish health ministry officials and scores of doctors corroborated these figures and said Poland will continue to die out slowly unless medical supplies and assistance are received.

Doctors estimated they need enough penicillin to treat 500,000 V.D. cases alone. They also need 30,000 beds and linen for them, 50 tons of soap monthly and standardized equipment and medicines of all kinds.

Only 6,000 doctors are available in Poland, and 3,000 of them are in the army. This compares with 13,000 before the war. There are only 450 health centres in the country and 1,500 druggists.

As one emergency measure, a cordon sanitaire has been established at customs points along the new western and eastern frontiers to check the thousands of repatriates moving in both directions.

Regina General to Build Wing to Nurses' Home

The Board of Governors of the Regina General Hospital is considering the addition of a new wing to the existing nurses' home, an addition made necessary by the expansion of the hospital itself, the new wing of which will be completed next year. This additional accommodation for nurses is expected to cost in the neighbourhood of $200,000.

Memorial Hospital at Saltcoats

A 15-bed Memorial Hospital to cost about $35,000, is planned for Saltcoats, Sask. The cost will be met by voluntary subscription.

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January to December

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